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wisconsin medical journal

JANUARY 1977

DHSS Secretary Carballo warns physicians they will need prior authorization under the Medical Assistance program when they designate "no substitution" for drugs in the Wisconsin Drug Formulary . . . see LETTERS, page 12

Late Development: Carballo agrees to drop proposal

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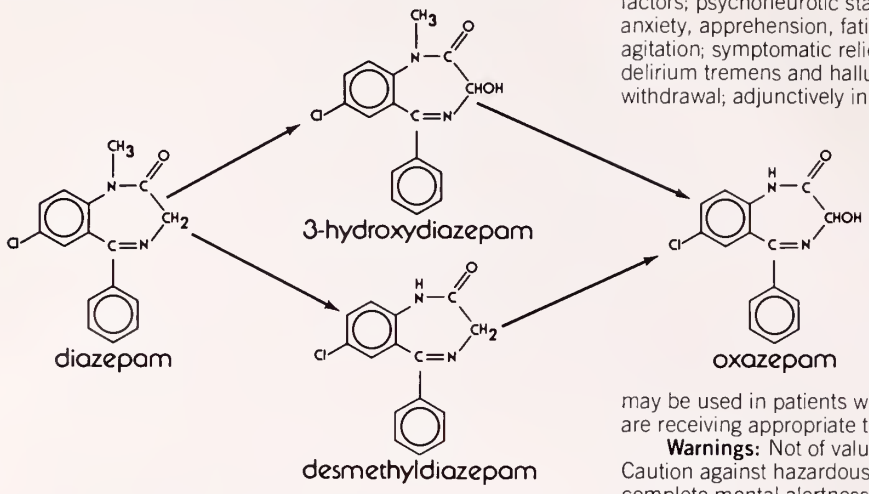

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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LIABILITY INSURANCE POOLS HEALTHY

The State Legislative Council's Malpractice Committee has issued a report showing that the two state-sponsored liability insurance funds are in seemingly good financial condition. The Committee reported at its November 30 meeting that the Wisconsin Health Care Liability Insurance Plan had received $15,190,902 in total premium payments as of October 31, 1976. Of that total, $9,969,-603 had been paid in by nearly 2400 physicians participating in the Plan. Claims paid as of 9/30/76 total $6,041 with $3,259 coming from a total of three successful claims filed against physicians. The Committee report resulted in a request by some members to lower the liability insurance premiums being assessed physicians, hospitals, and nurse anesthetists who are participants in the Plan. The Committee took no action on lowering of premiums leaving that option to the Board of Governors of the Plan. State Insurance Commissioner Harold Wilde was among those who cautioned against any reduction in premiums at this time saying that more experience is needed before the reductions can be approved. Since Wilde is also the chairman of the Board of Governors of the Plan, it appears that any decrease in premiums at this time is unlikely.

That same Malpractice Committee also heard a favorable report on the financial condition of the Wisconsin Patients Compensation Fund. As of October 31 the Fund balance was $4,616,000, and it was estimated that at the end of 1976 the Fund balance would be $7,500,000. After hearing that report the State Legislative Council's Malpractice Committee recommended that assessments to the Patients Compensation Fund be reduced after three years experience with the Fund or when it reaches $10 million, whichever comes first.

CERTIFICATE OF NEED PROPOSAL BY HEALTH POLICY COUNCIL

The Governor's Health Policy Council (HPC) has voted its support of a proposal that includes physicians' offices in a modified version of proposed certificate of need legislation. At its December 3 meeting the HPC endorsed a proposal which covers capital expenditures for physicians' clinical equipment which either exceeds $100,000 in cost or substantially changes the service of the facility. The modified version of the earlier proposed certificate of need legislation does, however, exclude brick and mortar expenditures for physicians' offices.

SMS OPINIONS ON MEDICAID GIVEN TO STATE OFFICIALS

The Wisconsin Medicaid Management Study Team (MMST) has received the views of the State Medical Society regarding the current operation of the T-19 program in Wisconsin. Responding to a request from the MMST for Society input, the Physicians Alliance Commission (PAC) explained in detail the SMS opinions on the shortcomings of the T-19 program. The PAC also indicated its feelings on which areas of T-19 should be upgraded both in service to the recipients and providers. The PAC communication to the State notes that Wisconsin's Medicaid program serves a great number of people, offers liberal benefits and is costly to state taxpayers. The State was told that many physicians do not have complete confidence in presentation of a T-19 card and suggested that a system be set up which would allow providers to check quickly to see if the person presenting a card is indeed eligible for Medicaid benefits. The PAC report also stressed the need for an improved payment procedure since now many physicians are waiting from six months to as long as two years before they are reimbursed for treating Medicaid patients. The PAC statement concluded with a suggestion that physicians be brought into the policy-making process of the T-19 Medicaid program. According to the PAC, Wisconsin officials currently are all but ignoring the considerable expertise that is available from physicians in the state. Expertise which, according to the report, is available for the asking and would be free of charge. The MMST was also told that currently the state Medicaid program suffers from lack of public confidence. That trend could be reversed, according to SMS, if the state works with the medical profession in improving and developing the program. ■

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Another Paradox of Government

AT THE NOVEMBER Council meeting the State Medical Society was faced with another of the strange paradoxes that so often arise when different aspects of government set out to define medical care of the public. Within our protective state borders the consumer of health benefits is now entitled by law to choice of provider; he or she can choose a chiropractor, a psychologist, a podiatrist, an internist, or a social worker, depending upon how he perceives his difficulty and whom he perceives able to help him with this difficulty. However, the Department of Health, Education, and Welfare at the National level has clearly stated, at least so far as nursing homes are concerned, that no monies shall be paid to any person on federal health and welfare programs (Medicare, etc) unless their "plan" for such care is organized by a physician (that is an MD, not any sort of doctor) and then that each separate consultant or participant in such care be approved by the physician and be part of his plan. Thus, if you disapprove of a nursing home patient's request for services of a social worker or of a chiropractor, or naturopath, or for a psychiatrist, then are you violating his rights to choice of provider; *OR* are you thereby depriving him of federal money assistance upon which he may be totally dependent? The Council labored mightily but did not solve this problem. It has, however, sought legal counsel pending clarification of several conflicts apparent in law and HEW rulings.—RH

Sick Society #3

ANOTHER REPORT out of Washington states that the number of legal abortions obtained by Washington residents last year exceeded the number of births in the District of Columbia. What's more, about 85% of the abortions were paid for by the government through Medicaid or at the free public hospital. The number of illegal, unreported abortions is a matter for additional speculation.

Other figures from Washington relate that more children there were born out of wedlock than were born to married women. This is the first major United States city where that has occurred.

This is indeed a sad commentary on our nation's capital, the fountainhead of legislation for national health care.—VSF

Things to Come

AN EXAMPLE of things to come with the inevitable increasing involvement of the Federal government in medicine is the cost of processing Medicare claims. A government study reports that it costs Social Security $12.39 to process every Medicare claim, but private carriers can do the same job for only $6.45. Each government worker processes only 2,500 claims a year *vs* 3,900 to 6,600 for private carrier employees who are paid a great deal less than the inflated bureaucrat wages in Washington.

Of course, physicians get credit for the high cost of medicine.—VSF

Psychotherapy Rears Its Ugly Head

THE NEWSPAPERS are full of what have been called abuses of the Medicare and Title XIX uses of psychotherapy. Some of this difficulty comes from the failure on the part of both government and the public to comprehend just what psychotherapy really is. The Council of the State Medical Society has called upon the State of Wisconsin to clarify this definition for purposes of reimbursement under the Medicare program. Your Council also approved Doctor Treffert's minority report of the advisory Committee on Mental Health Policy (to the State Government). This minority report took exception to that committee's actions which were primarily directed toward getting all sorts of providers covered by any state or federal money, rather than being concerned with a clearer definition of what services can and should be provided to those who so need. His report which was approved for backing by the SMS Council last November, contains this (paraphrased) idea: It is a political abuse of Medicaid to allow a whole variety of problems, such as educational, vocational, marital, behavioral, and the like, to be called medical simply because the money is available.

This abuse needs to be as diligently and carefully guarded against as provider abuse itself. Now direct provider abuse is a policing problem, not a medical one; it is now at least being performed by the proper federal and state agencies, even though some physicians continue to offer their police help. The larger question, of who shall provide, has been approached by Doctor Treffert and backed by your Council. But much further clarification can be done with only a little

effort.

There are many varieties of help offered to those in psychic, or psychosomatic, trouble. The simplest form is dogmatic assertion, and this can be done by anyone, usually the relatives telling the patient to snap out of it, get those ideas out of his/her head and the like; whole groups of professionals perform in this manner also, sometimes even physicians, but often psychologists or psychiatrists, Christian Scientists, and others.

A slightly more complex form presumes to know what is best for the designated patient and then proceeds to manipulate his life and loves in the direction desired by the therapist; examples can be found in the practices of psychiatrists, behavior therapy oriented psychologists, well meaning fatherly physicians, any variety of social worker or nursing personnel, music therapist, and the like. A third variety is the "get with it man, try this . . ." system, which can vary from a friend with a fresh supply of Mary Jane, to a sophisticated pattern of prescribed tranquilizers, (hopefully stopped before the irreversible tardive dyskinesia begins), to self-administered alcohol or barbiturates or bromides. A fourth variety, more dynamic in conception, can be defined as follows: "Medical psychotherapy: a medical procedure carried out by a physician trained in psychiatric medicine to treat mental, emotional, and psychosomatic illness through a relationship with the patient in an individual, group, or family setting. Medical psychotherapy always entails continuing medical diagnostic evaluation and responsibility and may be carried out in conjunction with drugs and other physical treatments. Medical psychotherapy subsumes that the psychological and physical components of an illness are intertwined and that at any given point in the disease process, psychological symptoms may give rise to, substitute for, or run concurrently with physical symptoms, and vice versa. Medical psychotherapy may encompass psychoanalysis, insight-oriented, behavior, re-educative, reconstructive, family, directive, supportive, and other forms of psychotherapy." This definition appears on page 129 of the official publication of the American Psychiatric Association (A Psychiatric Glossary), which was published in 1975 and could have been used by any state or federal agency, if such agency at that "point in time" had wanted a careful definition of psychotherapy. The SMS supported this definition but our State Legislature did not concur, passing instead the right-of-choice legislation.

The Council has, so far, continued to hold its position of fighting for some sort of medical standards; if this is abandoned, then I suppose we could go back to the 1900s and let the buyer have anything he wants but let him beware. This attitude is much easier than fighting continually and I suppose it gets votes in a medically unsophisticated populace. Somehow it doesn't seem, however, that *laissez-faire* is exactly that for which we all went to medical school.—RH ■

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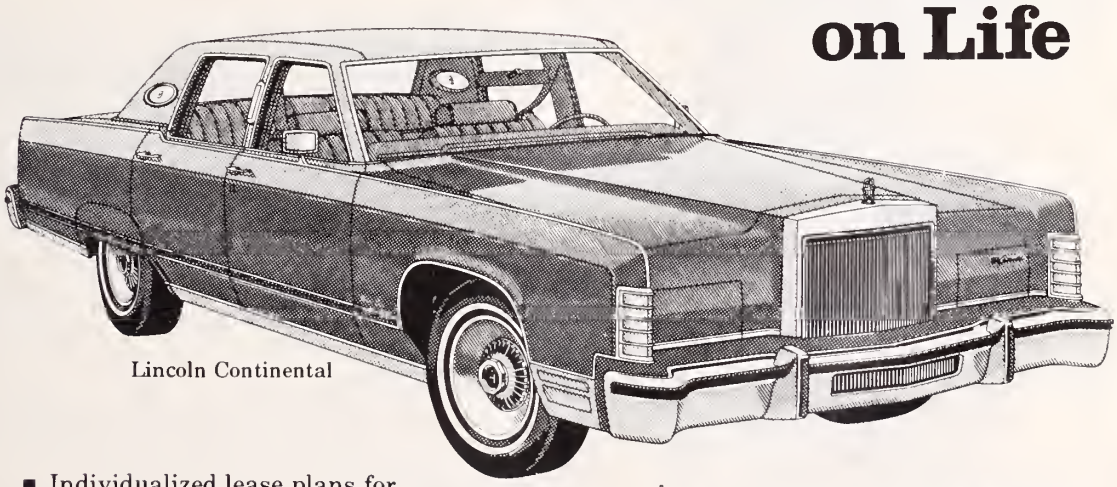

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Drug Formulary "Frustrations"

To the Editor: Containment of the cost of health care is a laudable goal in both the private and public sectors. Therefore, I was surprised and distressed to read in the *Wisconsin Medical Journal* (November 1976) that the State Medical Society is advising its membership to frustrate the work of the Wisconsin Drug Quality Council by eliminating generic substitution.

The article states: "The additional basis for liability created by the new law is failure of the physician to prohibit substitution in the proper case. Thus, where the compound prescribed is correct but it is claimed no substitution should have been permitted to the particular characteristics of one brand of the compound and the needs and condition of the patient, failure to prohibit substitution for the proper brand would be malpractice. Other bases and defenses to liability in the area of drug therapy are unchanged by the law."

This position assumes that the physician has complete knowledge of the source of the active ingredient, the fillers, binders and other excipients in all the brand name drugs in the Formulary. It seems highly unlikely that this is the case. In fact, most brand names are prescribed simply on the basis of familiarity either with the drug, its manufacturer, or his sales representative.

Since without prior authorization generic substitution will be required for items in the Wisconsin Formulary in the Medical Assistance Program, and since the list of items will be expanding rapidly, I hope you will reconsider this position.

I would be pleased to designate some members of the staff of the Department of Health and Social Services to work on this matter with you.

MANUEL CARBALLO, *Secretary*
Department of Health and Social Services
State of Wisconsin
Dec 14, 1976 Madison, Wisconsin

* * *

Editor's Note: A copy of the above letter was sent to Society Secretary Earl Thayer with the following additional comment: **"I want you to be aware that we will be requiring prior authorization under the Medical Assistance program for physicians who intend to designate 'no substitution' for drugs in the formulary.** I will communicate further with you when these prior authorization procedures have been developed."

* * *

To Mr Carballo: While we agree with your hope that the effectiveness of the Wisconsin Drug Formulary not be frustrated, I think you must also agree with the position of the Medical Society that the health care of patients not be endangered by substituting the Drug Formulary for medical judgment.

There seems to be an opinion, especially among legislators and government administrators, that the drugs listed in a formulary are by some magical process transformed into therapeutically equivalent products. There is substantial medical evidence to indicate that this is a false assumption. In addition, countless physicians tell of their unfortunate experiences with supposedly bioequivalent and therapeutically equivalent drugs. The Drug Formulary was and is a program supported

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vigorously by the State Medical Society despite the opposition of many of its members. The support of the formulary program, however, does not blind the Society nor doctors to the obvious necessity for the physician to give first and primary concern to the well-being of his patient. The moral, ethical, scientific and legal grounds for this cannot be disputed. When the Society advises its membership to use the words "no substitution" in situations where the physician believes the substituted drug might adversely affect the needs and condition of the patient, we think we are serving the public need to the highest possible advantage. Any other standard of care would be arbitrary and dangerous, and I do not believe that you or your office would support such a course of action simply because the patients are poor and on Medicaid. The position of the Medical Society is in no way designed to frustrate the effectiveness of the Drug Formulary and I am confident it will not do so.

The Society's officers, in the absence of any communication from your Department, feel there may be serious health care hazards, to say nothing of legal dangers and paperwork hassle, in the plan to require prior authorization when the physician believes a patient is best served by a specific drug remedy. We therefore request the opportunity to discuss this proposal with you, or appropriate representatives of the Department, prior to its implementation. We would particularly appreciate information concerning the medical rationale for possibly countermanding a physician's carefully reached decision as to a patient's needs.

EARL R THAYER, *Secretary*
State Medical Society of Wisconsin
Madison, Wisconsin

Dec 23, 1976

LATE DEVELOPMENT!

In a meeting December 31 with Society representatives, Secretary Carballo agreed to drop the prior authorization proposal if the SMS would agree to two points. Those two points, which were agreed to, include (1) setting up a monitoring survey to determine the use of NS prescriptions under the Medicaid program, and (2) continue efforts among physicians to encourage generic prescribing and dispensing where this is consistent with quality care for the patient and to assist in cost containment.

Name Surgicenter Is Trademarked

To the Editor: I recently read an article titled "Surgicenter Faces Possible Rejection" in the July 1976 edition of the *Wisconsin Medical Journal*. I note that in the article, the name Surgicenter® is used incorrectly. I would like to advise you at this time, that the name Surgicenter® is in fact a trademark and has legally been so since 1971, is owned by Surgicenters of America, Inc of Phoenix, Arizona and should be used to identify only those facilities under the control of Surgicenters of America. Through our continued effort, we have been able to insure that the name Surgicenter® stands for high quality surgical care over the past years and have vigorously defended it against infringement. I would appreciate in the future, you not referring to outpatient surgical units in general as Surgicenters®.

ROBERT C WILLIAMS
Executive Director, Surgicenter®
1040 East McDowell Road
Phoenix, Arizona 85006

Dr Alton Ochsner Biography Planned

To the Editor: We would be grateful if you could inform the members of your State Medical Society that a biography of Dr Alton Ochsner of the Ochsner Clinic, New Orleans, La is being prepared and that we would be most grateful to receive pertinent material in the form of opinions, evaluations, anecdotes, reminiscences, and photos. Photos will be carefully handled and returned.

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American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS JANUARY 1977

EARLIER THIS YEAR, we had the opportunity to tell you about the Certified Medical Assistant and how the Medical Assistant in your office can prepare for the Certification Examination. Some changes have taken place since then; and, of course, we want to keep you and your Medical Assistant informed and up to date of the progress of the American Association of Medical Assistants, Inc.

As you recall, we told you about the Mini-Test, a shortened version of the Certification Examination, which was offered yearly at the Wisconsin Annual Meeting. The Mini-Test has now been discontinued. The AAMA, Inc has developed a new method of testing and preparing potential CMAs for the Certification Examination. This educational tool is called the Self-Assessment Packet and is used by the Medical Assistant to test her knowledge and comprehension of the material she is required to know in her job. The Self-Assessment Packet is an examination consisting of one hundred questions constructed in the same manner as the actual Certification Examination. The questions vary in content from administrative procedures, to medicolegal law, to clinical aspects of the Medical Assistant's job, to insurance, and so forth. This packet is designed to give to a potential CMA an accurate idea of what material she needs to cover more thoroughly and what material she knows well before she attempts the actual Certification Examination. The answers for the test questions are included in the packet and thus the "student" may instantly evaluate the results of her own test.

Some advantages of the Self-Assessment Packet over the Mini-Test include the instant evaluation of test results, the flexibility of the Self-Assessment Packet in allowing the participant to take the two-hour examination at her convenience and in complete privacy, as well as the opportunity of each participant to use the Self-Assessment Packet when she feels that she is ready and prepared. With the Mini-Test, one could only take it when it was offered at an Educational Symposium or Annual Meeting. Now we have the opportunity for self-testing on an individual basis.

The Self-Assessment Packet was used at the Wisconsin Society's Educational Symposium in Eau Claire in October 1976. It was a mandatory part of the educational program and was well received. Wisconsin Society was a "testing ground" for the Self-Assessment Program to determine its usefulness for the Medical Assistant who is preparing for the Certification Examination.

The Education Committee and the Certification Committee of the State of Wisconsin were both involved in the presentation of the pilot program. An evaluation form was completed by those who participated in the Self-Assessment Examination. Specifically, the participants were asked to comment on the most effective part of the program. Many felt that the Self-Assessment Examination was more pertinent to the everyday jobs of the medical assistant than the Mini-Test had been. One participant stated, "Were I not a CMA, I would definitely have acquired the 'confidential' confidence to sit for the CMA exam."

If you already have a CMA in your office, the Self-Assessment Packet offers her a review, for "education is what you retain after you have forgotten all that you learned."

We must all continue active education, for our profession is ever-changing and requires constant updating. We hope that all physicians will encourage their Medical Assistants to participate in the Self-Assessment Examination and investigate the possibility of membership in the American Association of Medical Assistants.

Also, if you are interested in receiving information from a Doctor's point of view, please contact Doctor Raymond Baldwin, 1920 West Hart Road, Beloit, Wisconsin 53511. Doctor Baldwin has been an active supporter of the AAMA Wisconsin Society and is presently State Advisor for the Wisconsin Society as well as Advisor for Rock Chapter.

Self-Assessment Packets are available from the AAMA, Inc Chicago Office, One East Wacker Drive, Chicago, Illinois 60601 at a cost of $5.00. If you, or your Medical Assistant, has any questions regarding the AAMA or the Self-Assessment Packet or the Certification Examination, please contact the Certification Committee of the Wisconsin Society and we will help in any way we can.

JANE DOWDS, CMA-AC
708 North Arch Street
Janesville, Wisconsin
53545

LEORA LEE, CMA-AC
1017 Shirland Avenue
Beloit, Wisconsin
53511

Special Briefing on T-19

Representatives of Wisconsin's county medical and specialty societies were called to SMS offices in Madison last month for a special briefing on the current status of the Title 19 fee freeze.

Physicians Alliance Commission chairman Raymond Watson, MD, Milwaukee, through those who attended the special meeting, urged all state physicians to unite behind SMS negotiators in the Society's efforts to get the T-19 fee freeze lifted and secure a fair and equitable treatment of both providers and consumers of medical services.

The county and specialty society leaders also heard a report on the progress of the SMS T-19 lawsuit.

Another matter covered at the special meeting was a report on certificate of need legislation that physicians can expect to be introduced in this legislative session. SMS staff legislative staff told those attending the meeting that bills calling for the inclusion of physician's office equipment and hospital service licensure will most likely be included in certificate of need proposals.

SMS Physicians Alliance staff reported that physicians can also expect bills regarding professional liability to be introduced. Most probable are bills dealing with the shortening of the statute of limitations for physicians' liability in treating minors and the establishment of a 45-hour triennial continuing medical education requirement.

The special briefing session was called by SMS President Charles J Picard, MD, Superior. ■

SMS opinions on Medicaid given to state officials . . . see FRONT PAGE —UPDATE this issue. ■

Governmental Affairs Commission

The Governmental Affairs Commission has taken a strong position against a proposal which they feel, if adopted, would seriously undermine the authority of the Medical Examining Board. The Commission was responding to a proposal by the State Legislative Council which calls for a change in Wisconsin's occupational licensing laws.

Under that plan 10 of the existing 19 examining and regulation councils would be abolished. While the Medical Examining Board would be retained, the proposal suggests the creation of a separate appeals council chaired by the secretary of the Department of Regulation and Licensing with two other members appointed by the Governor.

The Commission also set up a special ad hoc committee to study all aspects of comprehensive state health insurance and catastrophic insurance. The Committee will study other comprehensive state health insurance plans and decide if the concept is an effective way to provide efficient health care to the citizens of Wisconsin.

Catastrophic insurance legislation which is scheduled for introduction in the current session of the Wisconsin Legislature will also be reviewed. ■

Jail Health

Twenty-eight inmates at the Eau Claire County Jail were examined recently as the initial phase of the SMS Jail Health Care Project concluded. The "inmate patient profiles" were conducted by members of the Eau Claire-Dunn-Pepin County Medical Society and by residents of the family practice program in Eau Claire. Other profiles were done at county jails in Milwaukee and Adams counties. The next phase of the project is the testing of the "Standards for Health and Medical Care in County Jails" in those same three counties. The goal of the project is to determine definite criteria for a certification process in the nation's county jails so that all inmates can be assured of proper medical treatment while incarcerated.

Annual Meeting

February 14, 1977 is the deadline for those who wish to submit resolutions for consideration at the Annual Meeting of the State Medical Society of Wisconsin. Also, a fiscal note on the resolution is required if it calls for studies, conferences, or other matters which would result in an expense or reduction in income. If needed, assistance in computing a fiscal note can be obtained from the Secretary's office at SMS headquarters in Madison.

Also, for all resolutions submitted a sponsor must be in attendance at reference committee hearings to provide any additional information that may be required. All resolutions must be submitted to the Secretary's office.

The Annual Meeting is scheduled for April 14-15-16 in Milwaukee. ■

Commission on Health Facilities and Services

The SMS Commission on Health Facilities and Services, at its December 1 meeting, unanimously approved a resolution calling for the Council to go on record as favoring county medical societies forming regional advisory committees to physician members of the Health Systems Agencies (HSA) boards in Wisconsin.

The Commission also approved a resolution of deep appreciation to Dale V Moen, MD, Shell Lake, for his many years of service as chairman of the Commission on Health Facilities and Services and former Commission on Hospital Relations and Medical Education.

Elected to succeed Doctor Moen as Commission chairman was Marvin G Parker, MD, Racine. Donald R Korst, MD, Madison was elected vice-chairman of the Commission. ■

SMS Variable Annuity Contract Unit Value

Beginning with this issue of the *Wisconsin Medical Journal* we will regularly report in this section the "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians. The unit value was $1.00 when the fund was established in October 1962. The unit value applies to the Prudential Variable Contract Investment Fund including both dividends and market value changes after provision for taxes, investment expenses, etc. For those participating in the SMS Program the unit value as of October 29, 1976 was $2.40. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

CORRECTION

Medicine seems to have its share of "same names, different people" and/or Juniors and Seniors which sometimes results in confusing information. Such is the case of Doctors John W Hayden and John W Hayden Jr.

In the Membership Report of September 3, 1976 (October *WMJ*) John W Hayden, LaCrosse, was transferred from LaCrosse County Medical Society to Pierce-St Croix County Medical Society when in fact John W Hayden Jr should have been reported as a new member of the Pierce-St Croix County Medical Society. In the Membership Report of November 1, 1976 (this issue of *WMJ*) the errors are corrected. John Jr is listed as a new member of Pierce-St Croix County Medical Society and John has been transferred back to the LaCrosse County Medical Society which he really never left. The Membership Department and the *WMJ* regret this error. Incidentally, Doctor Hayden Jr of Hudson is not a son of Doctor Hayden of LaCrosse, although Doctor Hayden of LaCrosse has a son named John who is still in high school.

* * *

In the Membership Report of October 15, 1976 (November *WMJ*) Phillip M Green of Marshfield, a new member of Wood County Medical Society, was reported as being certified in P (Psychiatry); however, Doctor Green is certified in Neurology (see also items in PHYSICIAN BRIEFS, November 1976 and January 1977 issues). The Membership Department and the *WMJ* regret this error.

Membership Report
November 1, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/subspecialty)

County Medical Society

ASHLAND-BAYFIELD-IRON

Gordon, Bruce D, 501 Copper St, Hurley 54534 (1948, Regular, Family Practice, Certified IM)
Parker, Eugenia H, 1615 Maple Lane, Ashland 54806 (1931, Regular, Clinical Pathology, Certified PD)
Phillips, Martin D, 614 Hillcrest Dr, Mellen 54546 (1946, Regular, Internal Medicine)
Rock, Ann M, 206 6th Ave West, Ashland 54806 (1949, Regular, General Practice)
Teoh, Ivan, 2101 Beaser Ave, Ashland 54806 (1944, Regular, General Surgery/Cardiovascular Surgery)

BROWN

Kuritz, Jay J, 3415 Hilltop Way, Green Bay 54301 (1948, Regular, Anesthesiology)
Leicht, Thomas R, 1821 S Webster Ave, Green Bay 54301 (1933, Regular, Internal Medicine/Cardiovascular Diseases)
Mardorf, Allen J, 1551 Dousman St, Green Bay 54303 (1943, Regular, Pediatrics/Hematology)
Schmacher, John P, P O Box 1081, Green Bay 54305 (1927, Regular, Anesthesiology)

LACROSSE

Deering, William M, 1836 South Ave, LaCrosse 54601 (1943, Regular, Child Neurology/Pediatrics)

OUTAGAMIE

Competente, Perfecto, 1608 N Hall, Appleton 54911 (1944, Regular, Anesthesiology)

PIERCE-ST CROIX

Hayden, John W, Jr, RR #2, Hudson 54016 (1941, Regular, Family Practice)

CHANGE OF ADDRESS

DANE

Zerofsky, Ronald, Madison, to 6239 E Charing Cross, Middleton 53562

MARINETTE-FLORENCE

Rogers, Raymond J, Oconto, to 111 Shore Court, Apt 114C, N Palm Beach, FL 33408

MILWAUKEE

Cotes, Eliecer, Milwaukee, to 960 Beau Drive Apt 102, Des Plaines, IL 60016
Kreuter, George C, Milwaukee, to 1112 Gooseberry Hill, Shreveport LA 71108
McGuinnis, Edward J, Milwaukee, to 546 W36528 Carriage Dr, Dousman 53118
Turcott, Richard D, Madison, to 9191 Watertown Plank, Milwaukee 53226

TREMPEALEAU-JACKSON-BUFFALO

Bollinger, John T, Mondovi, to 1428 Cummings Ave, Eau Claire 54701

WOOD

Strauss, George S, Marshfield, to St Louis Doctors Park, Minneapolis, MN 55405

COUNTY-TO-COUNTY TRANSFER

LaCrosse to Brown; Bolich, Paul R, 1586 Arapahoe Court, Green Bay 54303
Pierce-St Croix to LaCrosse; Hayden, John W, 1836 South Ave, LaCrosse 54601

DEATHS

Newman, John R, Dane County, Oct 10, 1976
Hermann, Weber C, Milwaukee County, Oct 18, 1976

Membership Report
as of November 30, 1976

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

BARRON-WASHBURN-BURNETT

Carlson, Stephen J, 209 4th Ave, West, Shell Lake 54871 (1946, Regular, Family Practice, Certified)
Conforth, Donald E, 336 Gerland Rd, Rice Lake 54868 (1942, Regular, Radiology, Certified)

BROWN

Baril, James D, 1551 Dousman St, Green Bay 54303 (1943), Regular, Orthopedic Surgery, Certified)

DANE

Babcock, Alan W, 131 W Wilson St, Suite 901, Madison 53703 (1944, Regular, Internal Medicine)
Bolles, J Craig, 36 S Brooks St, Madison 53715 (1945, Regular, Pathology, Certified)
England, Diane L, 4725 Sheboygan Ave, Madison 53705 (1947, Regular, Unspecified)
Lubinsky, Mark S, Dept of Pediatrics, 1300 University Ave, Madison 53706 (1948, Resident, Pediatrics)
Pearlman, Mary, 427 Lorch St, Madison 53706 (1946, Regular, Psychiatry)

MARATHON

Basu, Sailendra N, 1100 Lake View Dr, Wausau 54401 (1917, Regular, General Practice)

MARINETTE-FLORENCE

Hashimoto, Junju S, 2709 Richard St, Marinette 54143 (1943, Regular, Obstetrics and Gynecology, Certified)
Tsai, Jung-Nan, 1510 Main St, Marinette 54143 (1941, Regular, Pediatrics, Certified)

MILWAUKEE

Bellis, David N, 7635 W Oklahoma Ave, Milwaukee 53219 (1939, Regular, Obstetrics and Gynecology)
Cromwell, Charles L, 2388 N Lake Dr, Milwaukee 53211 (1943, Regular, Internal Medicine/Gastroenterology)

Cummins, Frank E, 2722 Oklahoma Ave, Milwaukee 53215 (1943, Regular, Internal Medicine/Cardiovascular Diseases)
Lawson, Russell K, 8700 W Wisconsin Ave, Milwaukee 53226 (1934, Regular, Urology, Certified)
Shah, Kanak K, 6000 S 27th St, Milwaukee 53221 (1940, Regular, Internal Medicine/Pulmonary Diseases, Certified IM)
Soni, Nalin S, 2243 N Prospect Ave, Milwaukee 53202 (1947, Regular Internal Medicine)

MONROE

Boyer, Richard P, 202 South K St, Sparta 54656 (1942, Regular, General Surgery)

PIERCE-ST CROIX

Kiernan, John H, 6049 Linden Rd, St Paul MN 55119 (1940, Regular, Family Practice/Radiology)

SHEBOYGAN

Moulton, Jonathan V, 1011 N 8th St, Sheboygan 53081 (1945, Regular, Internal Medicine/Gastroenterology)
Opel, D Douglas, 1011 N 8th St, Sheboygan 53081 (1945, Regular, Pediatrics/Pediatrics Allergy)
Schwalbach, John F, 1011 N 8th St, Sheboygan 53081 (1943, Regular, Internal Medicine/Cardiovascular Diseases, Certified IM)

WALWORTH

Cheung, Hoi-Yin, Kenosha St, Walworth 53184 (1945, Regular, Internal Medicine)
Cheung, Shung-Man, Kenosha St, Walworth 53184 (1949, Regular, Pediatrics)
Doreza, Edsel G, Kenosha St, Walworth 53184 (1943, Regular, Internal Medicine)
Fonmin, John, Kenosha St, Walworth 53184 (1936, Regular, Pediatrics)
Hart, Clarence R, 101 Broad St, Lake Geneva 53147 (1938, Regular, Orthopedic Surgery, Certified)
Rodcay, Thomas E, Hwy 50, Lake Geneva 53147 (1944, Regular, Ophthalmology)

WINNEBAGO

Dudley, Stephen S, 2952 Island Point Rd, Oshkosh 54901 (1944, Regular, Ophthalmology)

CHANGE OF ADDRESS

(Does not include those within a city)
County Medical Society

ASHLAND-BAYFIELD-IRON

Edwards, Paul K, Iron River, to 45-129 Mahalani Circle, Kaneohe HI 96744

BARRON-WASHBURN

Montemarano, VA, Rice Lake, to 7 Spring Cove Rd, Harbour Island, Narragansett RI 02882

DANE

Kim, Choong Man, Hendersonville NC, to Rte 2, Box 33, Foxhall Rd, Fletcher NC 28732
Kincaid, Charles K, Mobile, AL, to 3036 Waunona Way, Madison 53713

DODGE

Hansen, John P, Beaver Dam to 2318 Thunder Rd, Durham NC 27704

EAU CLAIRE-DUNN-PEPIN

Niver, Edwin O, Eau Claire, to PO Box 237, Chippewa Falls 54729

LACROSSE

Norris, Thomas C, LaCrosse, to 1419 Cedar Place, Onalaska 54650

LANGLADE

Lambert, Joseph W, Antigo, to 501 Roosevelt Ave, Eveleth MN 55734

MARATHON

Joosse, Peter C, Wausau, to 9191 Watertown Plank Rd, Wauwatosa 53226
Podoll, Lee N, Wausau, to 1866 S Grandview Lake, Bismark SD 58501

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Erwin, Constance J, Milwaukee, to 1166 Pilgrim Parkway, Elm Grove 53122
Krautkramer, Ronald, Janesville, to 4456 South 35th St, Greenfield 53221
Rabor, Antonio A, Cudahy, to 5832 Riverside Dr, Greendale 53129

MONROE

Harris, Arthur J, Smithfield VA, to 208 Monroe St, Sparta 54656

OUTAGAMIE

Anderson, Gay R, Winneconne, to 111 E North Water St, Neenah 54956
Malueg, Thomas J, Appleton, to 1028 Surrey Court, Neenah 54956

WOOD

Frazier, Ralph K, Marshfield, to Faerrel Clinic, Eldorado IL 62930
Nelson, Kenneth E, Marshfield, to 2232 North 7th, Grand Junction, CO 81501
Penner, Daniel B, Marshfield, to 7712 Circle Crest Rd, Louisville KY 40222
Shulman, Robert S, Marshfield, to PO Box 351, Bar Harbor ME 04609
Wolski, Kenneth P, Marshfield, to 6508 North Kenneth, Lincolnwood IL 60645

COUNTY-TO-COUNTY TRANSFERS

Eau Claire-Dunn-Pepin to Brown: Grieben, Leo R J, 130 E Walnut St, Green Bay 54301
Green to Brown: Hein, William E, 2410 Lina Lane, Green Bay 54304
LaCrosse to Dane: Lloyd, Baldwin E, 505 Melody Lane, Verona 53593

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DEATHS

Pierce, Dennis F, Milwaukee County, Nov 6, 1976
Schulz, Herman A, Marathon County, Nov 6, 1976 ■

OBITUARIES

◈ County, State, AMA Members

◈ **J Edwin Habbe, MD,** 77, Whitefish Bay, died Aug 31, 1976 in Glendale. Born May 8, 1899 in Indianapolis, Ind, Doctor Habbe graduated from Indiana University School of Medicine. Doctor Habbe had been in practice from 1928 until his retirement in 1964. He was a member of the faculty of Marquette University School of Medicine and had been chief of the medical staff at St Luke's Hospital from 1960-1962. Surviving are his widow, Frances; a daughter, Mrs John (Suzanne) Lehman, Aurora, NY, and a son Donald of Vermillion, SD.

◈ **Lien O Simenstad, MD,** 75, Osceola, past president of the State Medical Society of Wisconsin and former trustee of the American Medical Association, died Sept 11, 1976 in Osceola. Born Sept 26, 1900 in Northwood, North Dakota, he graduated from Rush Medical College, Chicago.

Active in the affairs of organized medicine, Doctor Simenstad served as State Medical Society president from 1956-1957, was speaker of the House of Delegates, councilor from the Tenth District, and a member of the Commission on Medical Care Plans. He was a delegate to the American Medical Association and was on the AMA Board of Trustees from 1963-1972. He also served as president of the Polk County Medical Society.

Surviving are his widow, Ethel; three sons, Dr John Simenstad, Osceola; Dr Paul Simenstad, Madison; Paul Kremser, University of Chicago; and a daughter, Betsy Kremser, Carleton College.

◈ **Arthur A Presti, MD,** 68, Milwaukee, died Sept 17, 1976 in Milwaukee. Born July 26, 1908 in Cleveland, Ohio, Doctor Presti graduated from George Washington Medical School, Washington, DC. Surviving are his widow, Lenore; and two sons, Mark and Paul.

◈ **Robert C Puestow, MD,** 55, Manitowoc, died Oct 7, 1976 in Manitowoc. Born June 7, 1921 in Oshkosh, Doctor Puestow graduated from the University of Wisconsin Medical School, Madison. He became associated with the Manitowoc Clinic in 1951. Surviving are his widow, Claramae; five sons, Dr. Eric P Puestow, Jacksonville, Fla; Robert, Frederick, Karl and Jacob of Manitowoc.

◈ **Olaf E Satter, MD,** 85, Prairie du Chien physician for over 50 years, died Oct 8, 1976 in Middleton. Born Sept 21, 1891 in Morris, Minn, Doctor Satter graduated from Loyola University Medical School, Chicago. Doctor Satter served as president of the Prairie du Chien General Hospital for many years and was a president of the Crawford County Medical Society. Surviving are his widow, Bernice; two daughters, Mrs Orrin (Bernice) Rongstad, Middleton; Mrs Gary (Sonya) Dailey, Montford; and two sons, Rodney, Prairie du Chien, and Dr Erby, Sacramento, Calif.

◈ **John Robert Newman, MD,** 89, Madison, died Oct 10, 1976 in Madison. Born Mar 10, 1887 in Madison, Doctor Newman graduated from Rush Medical College, Chicago. He worked with the University of Wisconsin Student Health Center before becoming the physician for the Rock Island Railroad. He retired in 1958. Since 1961 he had served as a volunteer physician for the Dane County Red Cross Center. Surviving are a brother, Edward; and two sisters, Irene, and Rose of Madison.

◈ **Weber Conrad Hermann, MD,** 75, Elm Grove, died Oct 18, 1976 in Milwaukee. Born on Jan 4, 1901 in Muscatine, Iowa, Doctor Hermann graduated from Northwestern University Medical School in 1928. He was a member of the American Academy of Family Physicians. Surviving are his widow, Mildred; four sons, Donald W, Thomas, Fred, Dr Weber C; and two daughters, Mrs Arthur (Lucille) Stahl, and Mrs Victor (Marie) Mader.

◈ **Herman A Schulz, MD,** 77, Edgar, died Nov 6, 1976 in Wausau. Born Mar 7, 1899 in Random Lake, Doctor Schulz graduated from Marquette University School of Medicine in 1924. He had served as president of the Marathon County Medical Society, and in February 1973 he received the LaCount Award for distinguished medical service. Surviving are his widow, Amelia; two daughters, Mrs Robert Schulte, Milwaukee, and Mrs Gordon Lew, Tulsa, Okla; and two sons, Herman Jr of Edgar, and John of Lawrence, Kan.

◈ **Dennis Francis Pierce, MD,** 74, Hales Corners physician for 50 years, died Nov 6, 1976 in Hales Corners. Born Feb 8, 1902 in Chicago, Doctor Pierce graduated from Marquette University School of Medicine in 1925. He served as city health officer for the village and city of Greenfield, Franklin, and Hales Corners. Doctor Pierce also was a councilor of the State Medical Society of Wisconsin from 1949-1952. Surviving are his widow, Leota; a son, Thomas of Elyria, Ohio and a stepson, Richard Noll of Jackson, Fla. ■

NEWS HIGHLIGHTS

Riverview Hospital

. . . in Wisconsin Rapids was host to 76 health-care professionals from seven counties in central Wisconsin attending a workshop on "Mothers and Infants at Risk" November 19. The workshop was presented by physicians, nurses, social workers, nutritionist and administrative staff members of the North Central Wisconsin Perinatal Center based at St Joseph's Hospital/ Marshfield Clinic, Marshfield. Counties are: Portage, Wood, Marathon, Clark, Juneau, Jackson, and Adams.

Topics included a variety of risks faced by mothers and infants, including the jaundiced infant, importance of continuity of care, hypertension during pregnancy, obstetrical emergencies, prenatal nutrition counseling, resuscitation of the newborn, and related topics.

Institutions and agencies represented included the Mauston Clinic and Hess Memorial Hospital, Mauston; Adams County Memorial Hospital, Adams-Friendship; Riverwood Clinic, Doctor's Clinic, Riverview Hospital, and Children's Service Society, Wisconsin Rapids; Memorial Hospital, Neillsville; Black River Memorial Hospital, Black River Falls; St Michael's Hospital, Stevens Point; Wausau Hospitals North and South and Visiting Nurse Association, Wausau; St Joseph's Hospital and Marshfield Clinic, Marshfield; UW-Stevens Point faculty; Great Lakes Intertribal Council, Lac du Flambeau; Clark County Social Services, Neillsville; Wisconsin Division of Health personnel, and many individual professional practitioners.

The workshop is one of a series of educational programs offered by the Perinatal Center staff in the North Central Region, in local locations for easy access.

Prevention of Coronary Artery

. . . disease was the subject of Parkview Medical Associates 8th Annual Educational Program November 11 at the Hartford Union High School in Hartford. MDs John Manley,* William Gallen,* and Richard Zimmerman* gave a panel discussion of the factors known to contribute to coronary artery disease. Doctor Zimmerman's discussion of Type A behavior pattern was especially interesting to the audience, Dr Parnell Donahue* of the Parkview Medical Associates reported.

The program was videotaped by the Hartford High School audiovisual department and will be shown to the high school health classes as part of their ongoing health program. The program also will be broadcast over the local cable television Channel 11. This is the second year the Parkview educational program has been open to the public. Last year's topic of middle age and post menopausal depression also was videotaped for community education over Channel 11.

Doctor Manley is president of the Wisconsin Heart Association, Doctor Gallen, chairman of the Department of Pediatric Cardiology, Medical College of Wisconsin; and Doctor Zimmerman, instructor, Department of Psychiatry, MCW.

Six UW-Madison Med Students

. . . seniors have been awarded MAP-Reader's Digest International Fellowships for the next year. Made possible by a grant from the founder of Reader's Digest, the program provides three-month assignments to rural mission hospitals and clinics in remote parts of the Third World.

The UW-Madison students are among 31 medical students from the United States and Canada who will participate in programs offered by the local hospital and clinic staffs where they are assigned.

Recipients and their assignments are as follows:

Peter Hamel, Monrovia, Liberia, February-April 1977; Loreen Herwaldt, Pakistan, January-March 1977; Ramona Johnson, Sierra Leone, December 1976-March 1977; Lynn Martin, Monrovia, Liberia, March-May 1977; David Spriggs, Ganta Liberia, March-May 1977; Sylvia Weir, Kijabe, Kenya, December 1976-February 1977.

PHYSICIAN BRIEFS

Michael P Mehr, MD*

. . . member of the medical staffs of the Marshfield Clinic and St Joseph's Hospital and an assistant clinical professor at the University of Wisconsin, Madison, recently was appointed trustee of the American Society of Internal Medicine. Doctor Mehr also is president-elect of the Wisconsin Society of Internal Medicine. He was appointed to fill a vacancy created on the Society's 13-member board by a resignation.

Walter F Smejkal, MD*

. . . Manitowoc, recently was elected chief of the medical staff of Holy Family Hospital. Doctor Smejkal received his medical degree from the University of Illinois College of Medicine and has been a member of Holy Family Hospital's medical staff since 1951.

Herbert M Aitken, MD*

. . . Eau Claire, recently was appointed first medical examiner of Eau Claire County. His position replaced the coroner's position. Doctor Aitken, a 1929 graduate of the University of Wisconsin Medical School, Madison, served as a commander in the Medical Corps of the U S Navy Reserves and had practiced radiology in Eau Claire since 1952 until his retirement in July 1976.

Robert Monk, MD*

. . . Waukesha, recently was elected as chief of the Department of Surgery of Waukesha Memorial Hospital.

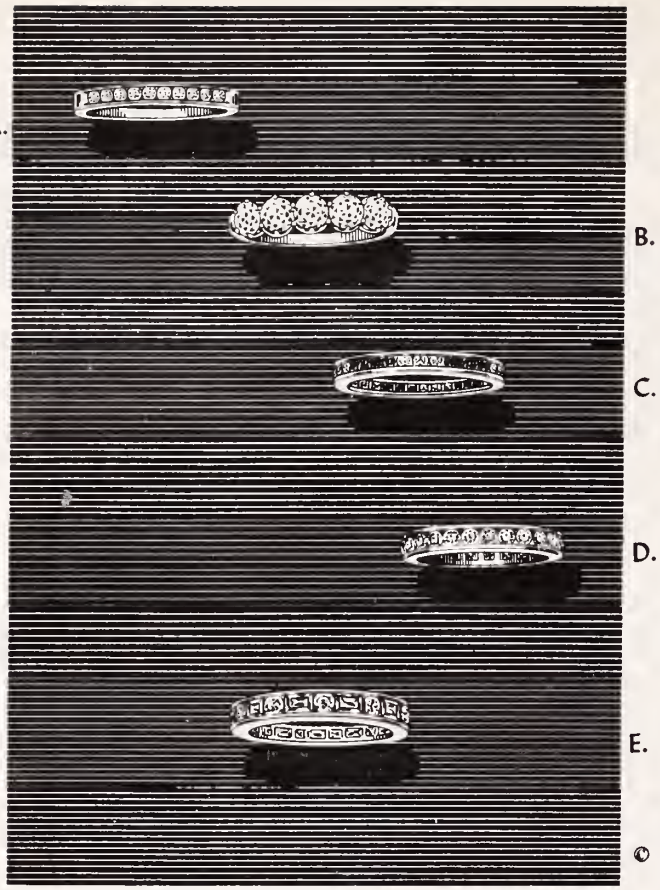
Bill Catelli, MD

. . . recently opened his medical practice in Clear Lake. A graduate of Loma Linda University Medical School, Doctor Catelli had been serving as a Public Health Service physician in Arizona before moving to Clear Lake.

E R Jonas, MD*

. . . Ellsworth physician, recently was reelected president of the American Cancer Society, Wisconsin Division at the Annual Meeting.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.



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George Kindschi, MD
Bharathy Nair, MD
Paul Nemovitz, MD

. . . Monroe, recently became associated with the Monroe Clinic. Doctor Kindschi, whose father Leslie G Kindschi, MD* has been a member of the Clinic since 1941, is the Clinic's first pathologist. A 1968 graduate from the University of Wisconsin Medical School, Madison, he completed a rotating internship at Great Lakes Naval Hospital and served his residency at Bethesda Naval Hospital. Doctor Kindschi had been director of laboratories for the past year at Great Lakes prior to leaving the Navy. Doctor Nair, whose husband, V K Nair, MD* also is a member of the clinic, is a general practitioner and graduated from S V Medical College, India. Her internship was completed at the Monroe Clinic and St Clare Hospital. Doctor Nemovitz, an internist, graduated from the University of Wisconsin Medical School, Madison, and completed his internship and residency at Gundersen Clinic Ltd-Lutheran Hospital in LaCrosse.

Vincent Nordholm, MD*

. . . Stoughton physician for 30 years, recently was honored by the Stoughton Hospital Foundation. He was presented with the first "Distinguished Service Award" for his services to the people of Stoughton.

Jerry Salan, MD*

. . . Waupaca, recently was named "Outstanding Businessman of the Year" by the County Chamber of Commerce. Doctor Salan was cited for his contribution to the area's economic growth and for his dedication to serving the area as a physician and always striving for better medical conditions and education.

Frederick Reinke, MD

. . . an internist, recently joined the staff of Medical Associates Clinic, Menomonee Falls. Doctor Reinke graduated from the University of Wisconsin Medical School, Madison, in 1971 and completed his internship and residency at Good Samaritan Hospital Phoenix, Ariz and Mt Sinai Medical Center, Milwaukee.

John E Lent, MD*

. . . Fond du Lac, recently was granted a Fellowship in the American College of Cardiology. Jack C Manley, MD,* Milwaukee, the ACC Governor for Wisconsin listed the new Fellow.

Daniel M Pick, MD*

. . . Manitowoc, chief of the medical staff of Holy Family Hospital from 1974-1976, recently received a plaque of honor for his services. A 1942 graduate of Marquette University School of Medicine, Doctor Pick has practiced medicine in Manitowoc since 1950.

Robert Senty, MD*

. . . Sheboygan, recently became medical director of the We Care Nursing Home in Sheboygan. Doctor Senty is the 1975 recipient of the University of Wisconsin Medical School's Max Fox Preceptor Award for his long service to medical education. He has been a member of the Sheboygan Clinic medical staff since 1954.

Joseph Springberg, MD*

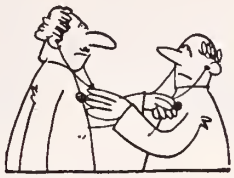
. . . Beloit, recently retired from private practice. He will continue as director of the Beloit Health Department and as medical director of Caravilla Retirement and Skilled Nursing Facility. He has been in private practice for 40 years.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF DECEMBER 1976

1 SMS Commission on Health Facilities and Services
1 Dane County Medical Society Interprofessional Committee
6 Dane County Medical Society Insurance Advisory Committee
6 Dane County HMP Committee
7 Dane County Medical Society Board of Trustees
8 WHCRI-HIAC & WHCRI Ad Hoc Committee
8 SMS Commission on Governmental Affairs
8 Dane County HMP Guidelines
9 Dane County HMP Guidelines
10 Ad Hoc Committee on Professional Liability and SMS Physicians Alliance Commission
11 WPS Commission (WPS Building)
15 WisPRO Executive Committee
15 Ad Hoc Committee on Chiropractic
16 Health Screening and Immunization Committee
16 Board of Directors, Convention Bureau
16 Conference on Negotiations
17 Subcommittee on Accreditation, SMS Commission on Continuing Medical Education
17 SMS Committee on Evaluation of Delivery and Cost of Medical Care
21 WisPRO-FMCE Long Term Care Review Committee
22 SMS Council Committee on WHCRI and WisPRO

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parentheses.

"Hey, SMS"



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COCKTAIL LOUNGES . . . two in number.
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An Affiliation Agreement

. . . between De Paul Rehabilitation Hospital and the Medical College of Wisconsin, Milwaukee, has been signed. The affiliation enables the two institutions to cooperate in educating medical students and resident physicians in the treatment of alcoholism, and to conduct joint programs of research.

David Carley, president of the medical college, and A Bela Maroti, president of De Paul, made a joint announcement of the agreement.

"At De Paul, medical students will have an opportunity to develop an understanding of alcoholism and recovery by direct involvement with these patients and their families. Our research studies will give opportunities to learn of approaches that may become treatment in the future," said Maroti.

Carley said, "This is an important affiliation for the medical college. Alcoholism is poorly understood by many physicians. We want our graduates to be prepared for treating a disease which affects the lives of so many."

According to recent figures of the Wisconsin State Alcoholism Plan, an estimated 87,543 persons in Milwaukee County are alcoholics or alcohol abusers and they account for approximately one third of admissions to state and county hospitals.

Medical students at MCW will be offered training at De Paul as an elective through the college's department of preventive medicine.

Resident physicians who are in specialty training for psychiatry or family medicine will be offered an elective rotation at De Paul in addition to rotations through other MCW affiliated hospitals.

The joint program will be managed through De Paul's department of research, evaluation, and training.

St Joseph's Hospital

. . . in cooperation with the Marshfield Clinic in mid-November submitted for approval to the North Central Area Health Planning Association plans for the development of a 12-bed adolescent psychiatric unit. The proposed unit will be located, through leasing of space, within the Norwood Health Center facility in Marshfield, and will be operated by St Joseph's Hospital with medical staffing being provided by the Marshfield Clinic. Potential patients for the unit will be emotionally disturbed, behaviorally disturbed, and drug dependent children/adolescents, between the ages of 10 and 18, who need crisis intervention care rather than long-term residential care. Opening of the unit is contingent upon approval by the health system planning process, staff recruitment, and finalization of the proposed lease arrangements, according to the St Joseph's Hospital announcement.

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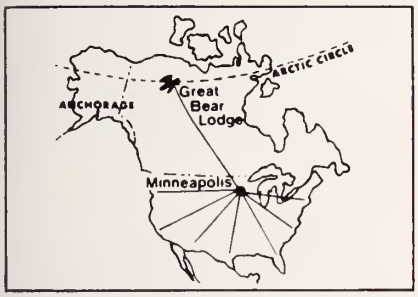

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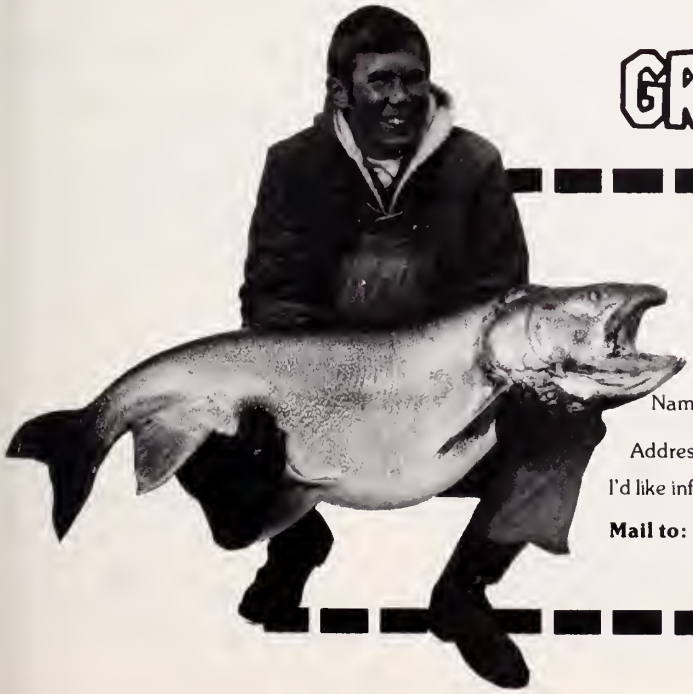

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Robert Zach, MD*

. . . member of the medical staff of the Monroe Clinic, recently was featured in a Madison newspaper for his large collection of Aesculapian staffs. Doctor Zach has been collecting the staffs for over 15 years and is reported to have the largest collection, over 200, in the world. The medical staffs which are known as the mythical god of medicine, come from people all over the world and Doctor Zach has made quite a few himself.

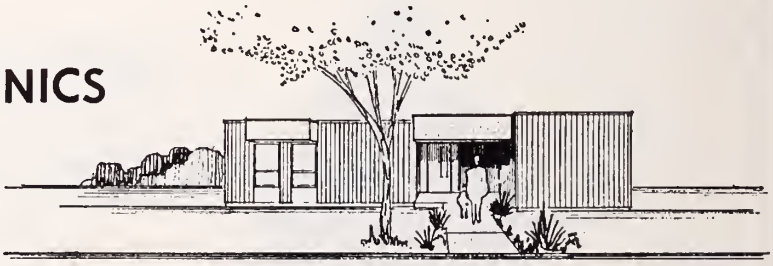
Donald R. Griffith, MD*

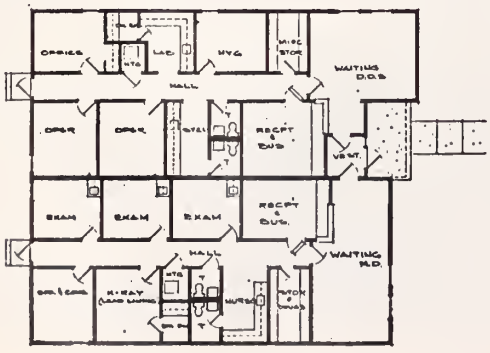
. . . chief executive officer of the Midelfort Clinic Ltd, Eau Claire, recently was voted president-elect of the American Group Practice Association at the Annual Meeting. An internist, Doctor Griffith is a member of the American College of Physicians and has served as a member of the AGPA Board of Trustees since 1973.

Phillip M Green, MD*

. . . who recently joined the Marshfield Clinic in the Department of Neurology (reported in the November issue of *WMJ*), completed three years of residency in neurology at Washington University School of Medicine, St Louis, Mo. While at the Portsmouth (Va) Naval Regional Medical Center. Doctor Green was an assistant professor in the Departments of Neurology and Medicine. He also has completed his boards in neurology.

MEDICAL & DENTAL CLINICS





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Care of Mothers and Infants

. . . was the topic of a November 17 workshop presented by the professional staff members of the North Central Wisconsin Perinatal Center at St Joseph's Hospital/Marshfield Clinic in Marshfield. Fifty-six public health nurses, nutritionists, and other health care professionals from the 21-county Perinatal Center region heard presentations on topics involving premature infants, parent-infant interaction, nutrition needs of mothers and infants, the Perinatal Center communication network within the community, and other topics presented by physician, nursing, nutritionist, and social work members of the Perinatal Center staff.

Among those attending were representatives of public health departments, city health offices, schools and other health agencies from Barron, Chippewa, Clark, Eau Claire, Juneau, Lincoln, Marathon, Portage, Sawyer, Taylor, Washburn, Waupaca, Waushara, and Wood Counties, the city of Wausau, State Division of Health representatives from Madison, Eau Claire, and Rhinelander, and the Great Lakes Intertribal Council, Lac du Flambeau.

Critical Care Medicine

. . . the Wisconsin Society of Critical Care Medicine is entering its second year of activities as a viable and active organization, Dr Burton A Waisbren,* Milwaukee, reports.

The symposium held in LaCrosse October 30, 1976, was well attended. The faculty consisted of Doctors Guenther Pohlman,* Burton Waisbren,* Adolf Gundersen,* Daniel Kincaid,* and Marvin Birnbaum.

The Society, encouraged by the capacity turnout of its first Critical Care Symposium April 9-10 at Lutheran Hospital in Milwaukee, has decided to repeat the Symposium April 22-23 at Lutheran Hospital in Milwaukee.

Dr Max Weil of Los Angeles has accepted an invitation to be the guest professor at the Symposium. Doctors throughout the State who are interested in membership are invited to join the Society.

Requirements for membership are a degree in Medicine or Medical Engineering and an enthusiastic interest in the care of the critically ill.

Dues are $10.00 per year. Contact Shirley Hagen, Executive Secretary, 700 North Water St, Milwaukee, Wis 53202 for membership applications. ■

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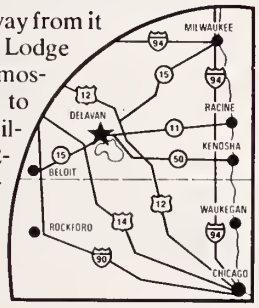

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Armand J Quick, MD*

. . . recently published his seventh and eighth books: *Bleeding, Drugs, Vitamins: Their Impact on History,* and *Detecting and Managing the Vitamin K-Deficient Patient.* The 82-year-old retired research professor of the Medical College of Wisconsin, Milwaukee, combines an autobiography and history in the seventh book, written for the scientific and lay audience, which represents the culmination of an illustrious career in medical teaching, research, and practice. Distribution of the book is being made through the Public Relations Department of the Medical College. The eighth book is a manual for hospital-based physicians and is being presented by Merck Sharp & Dohme as a service to medicine.

Garry A Quinn, MD*

. . . Sheboygan, recently was elected president of the St Nicholas Hospital Medical and Dental staff. Also elected were MDs Edward G Schott,* vice-president, and Burnell F Eckardt,* secretary-treasurer, Sheboygan. Terms are for one year.

Kenneth L Day, MD*

. . . Wausau, recently was reelected president of the Wausau Medical Center. MDs Thomas A Starkey* and Robert E Cadwell,* Wausau, will serve as vice-president and secretary-treasurer, respectively.

Malcolm Schmehl, MD

. . . Durand, recently became associated with David Castleberg, MD, in the Durand Medical Clinic. He graduated from Loma Linda University Medical School and completed his internship and residency at Spartanburg, Tenn.

Karen S Schmahl, MD*
Ming-Jyi Tsao, MD*

. . . Mequon and Milwaukee, respectively, were recently certified as Fellows of the American College of Anesthesiologists. Both are in residency training with the Medical College of Wisconsin Affiliated Hospitals in Milwaukee.

George C Liang, MD*
Lawrence S Larson, MD*

. . . LaCrosse and Milwaukee, respectively, were honored recently by admission to the membership category of Fellowship by the American College of Physicians. ■

Breast Cancer Management —1977

On Saturday, February 26, 1977 a conference on breast cancer management will be held in Red Wing, Minnesota. Dr Jack Falls will moderate. The principal speakers will be Drs Philip R Karsell, James Hoehn, Erhard Haus, Donn G Mosser, and Paul P Carbone. Reservations may be made by contacting Mr James Sasser of the American Cancer Society, Wisconsin Division, Inc, 611 North Sherman Ave, Madison, Wis 53704.

Current Status of Bronchogenic Carcinoma

Bronchogenic carcinoma[1] is really four distinct diseases (epidermoid carcinoma, small-cell carcinoma, adenocarcinoma, and large cell anaplastic carcinoma) which differ in presentation, tendency toward early metastasis, and response to therapy.

Early detection would help improve prognosis, because bronchogenic carcinoma metastasizes early. The most promising method is serial collection of sputum for cytologic examination, in which shed cells show increasing degrees of cytologic atypia long before malignancy can be detected.

The primary purpose of staging[2,3] is to determine tumor resectability. Angiography and mediastinoscopy can establish nonresectability in about one-third of patients clinically believed operable. In the future, use of tumor-seeking radionuclides, diagnostic ultrasound, and brain and whole body scan may help.

For most patients, surgery is the only chance of cure. Its success depends upon the state of the disease and physiologic state of the patient —whether the patient can survive surgery, cardiopulmonary reserve, and renal and liver function. Staging is often recorded in the tumor-node-metastases (TMN) system, which correlates with prognosis for all histologic cell types except small cell carcinoma. Small cell carcinomas usually present as Stage III. Most surgeons agree that patients with Stage I and II epidermoid carcinoma, adenocarcinoma, and large-cell anaplastic carcinoma should have surgery if physiologically possible, but a diagnosis of small-cell carcinoma is a contraindication to surgery. Tumors should be completely resected, but as little lung tissue as possible should be sacrificed. Extension of tumor outside the nodal capsule and involvement of nodes high in the mediastinum make it unlikely that 5-year survival would exceed expected surgical mortality. There is little indication for palliative resection.

Factors favorably influencing survival of patients with resected cancer are low disease stage, age below 60 years, and right lung involvement. Unfavorable factors are related to weight loss, pre-existing pulmonary disease, need for pneumonectomy, and blood vessel or lymphatic involvement.

Radiation therapy represents localized treatment for localized disease so requires accurate staging to be curative. The patient's physiological status must be evaluated. Poor survival in patients with local control of the disease may be due to subclinical systemic metastases at the time of therapy, immunosuppression, and toxicity. Radiation pneumonitis and fibrosis are significant complications. The minimal dose of radiation necessary for sterilization of disease is apparently above 4000 rads. Split course techniques may give better results than continuous radiation. The major value of radiation therapy is palliation of symptoms such as pain, cough, hemoptysis, neurologic symptoms, and superior vena caval and bronchial obstructions. Palliation can be achieved in 75% of patients receiving smaller doses of radiation than used for curative attempts. Better dose fractionation schemes and high linear energy transfer particles are being studied, which should be more effective and distribute radiation energy better.

Combination chemotherapy has produced partial responses in over 50% of patients with small cell carcinoma and complete response in 10-30%, but improved methods of remission consolidation and maintenance are needed. With other types of bronchogenic carcinoma, significant complete tumor regressions have not been achieved and only slight increases in survival recorded. Surgical adjuvant chemotherapy and combined radiation therapy-chemotherapy have not been successful.

Immunotherapy may be useful in lung cancer patients. Patients with reactivity to recall skin test antigens or who develop empyema postoperatively have a better prognosis.

Hopefully soon we will be able to find a way to more successfully treat this group of lethal cancers.
—Dorothy J Buchanan-Davidson, PhD, Wisconsin Clinical Cancer Center

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

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References

1. Cohen, Martin H. Lung Cancer: A Status Report. Journal of the National Cancer Institute 55:505-11, 1975.
2. Carr, D. T.; Mountain, C. F. The Staging of Lung Cancer. Semin. Oncol. 1:229-34, 1974.
3. Muggia, F. M.; Chervu, L. R. Lung Cancer: Diagnosis in Metastatic Sites. Semin. Oncol. 1:217-28. 1974.

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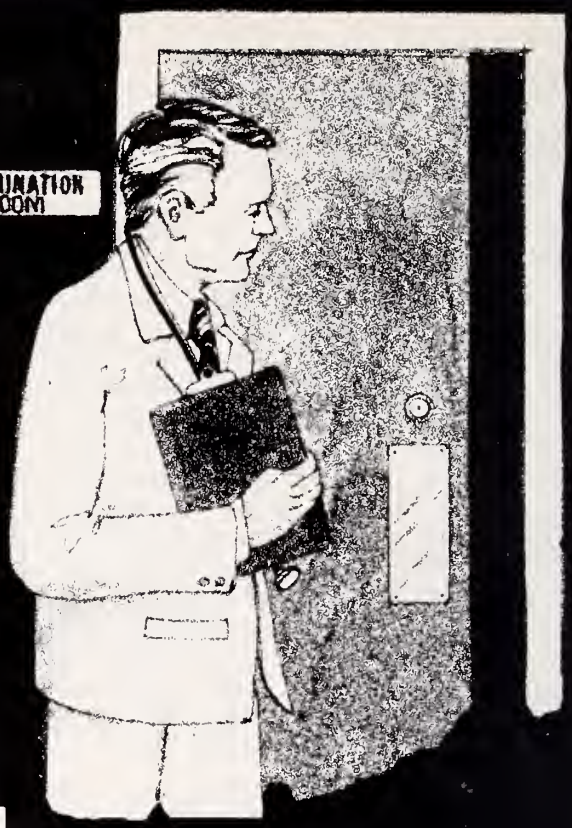

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Volume VI, Number 1 January 1977

Fee Screen Payment Levels

REMINDER: At the March 1976 Annual Meeting of the State Medical Society House of Delegates, action was taken by the House in regard to the mechanism that is to be followed by WPS in determining fee screen payment levels. A "fee screen level" is a fee level above which fees will be subject to further review to establish their reasonableness.

Under the House action, the county medical society fee advisory committee will continue to function as the primary resource in recommending ranges of local fee levels. The WPS Claims Committee, which is a sub-committee of the WPS commission, will have the responsibility for determining whether or not WPS payment levels will be modified.

Further, per House action, the Claims Committee must work within the following guidelines: Requests for increases in fee screen levels must be received 120 days in advance of the proposed effective date of such changes. Secondly, consideration of requests for increases are limited to no more than once in 12 months.

In addition to receiving information from the various insurance advisory committees throughout the state, WPS staff does provide the Claims Committee with statistical data relative to "charge" levels on both a local and statewide basis. These reports are generated via the WPS computer system and furnish the Committee with an opportunity to compare the actual charges submitted by physicians versus the requested fee screen levels.

If the Claims Committee does modify the request from the insurance advisory committee, the committee will be informed as to that action and will be requested to provide supplemental documentation to support their request. Therefore, it is important that as much information as possible be included in the original request for a change in the fee screen payment level.

If you should have any questions or comments in regard to this matter, please contact the WPS Claims Department.

For further information contact Wisconsin Physicians Service:

WPS
WISCONSIN PHYSICIANS SERVICE
1717 West Broadway, Box 1109, Madison Wisconsin 53701

***Report** is a service to the physicians of Wisconsin.*

The Blue Shield Plan of the State Medical Society of Wisconsin

and their Medical Assistants

Regular WPS Contract Benefits and Exclusions

A common question asked by Medical Assistants is, "What benefits and exclusions are included in regular WPS policies?" We are aware that many patients insist that a Physicians Service Report be filed for routine office calls, periodic or annual examinations, injections, immunizations, etc.

Contracts written by WPS generally provide coverage for services rendered by physicians in the diagnosis or treatment of disease or injury as accepted by the medical profession. The categories listed below are the most frequently questioned and are covered benefits under many WPS policies.

EMERGENCY FIRST AID - Benefits provided for the initial exam and treatment of accidental injury. Some policies provide additional follow-up benefits. Example: bee sting, food poisoning.

MEDICAL EMERGENCY CARE - Benefits provided for the initial examination and treatment of any condition or symptom which is severe or acute, and occurs suddenly and unexpectedly. Example: acute allergic reaction, acute or possible appendicitis, severe chest pains, fainting, etc. Again, some WPS policies provide followup care. Medical emergencies are increasing faster than any other utilization trend. The emergency room is not a substitute for the physician's office.

DIAGNOSTIC X-RAY AND LAB - Benefits provided for lab and x-ray examinations related to the diagnosis and treatment of the illness or injury.

- Standard exclusions in WPS policies are:
- Examinations and tests in connection with research studies.
- Routine or periodic exams
- Pre-marital or pre-employment exams
- Examinations not directly related to the diagnosis of the illness or injury
- Lab and x-ray not related to the diagnosis or injury. Example: diagnosis - otitis media; procedure - x-ray right foot.
- Lab and x-ray in connection with annual or periodic exams and third party examinations. Example: diagnosis - employment exam; procedure - chest x-ray, urinalysis. Both procedures are excluded.

We are all bogged down by paperwork. It is expensive for both your office and WPS to process claims forms for services that are not benefits of regular WPS policies.

WPS

TWO FAMILY PRACTITIONERS urgently needed to join a progressive established group of four providing quality health care in a community of 10,000, serving an area of 24,000. Modern clinic with well equipped x-ray and laboratory facilities in a pleasant clean environment located at the "Doorway to the North." Diverse recreational activities. 100-bed accredited open hospital. Guaranteed $36,000 the first year with excellent fringe benefits. Contact Ted Fox, MD, J E McKenna, MD or J O Moermond, Jr, MD, the General Clinic, SC, 2nd and Clermont St, Antigo, Wis 54409. Tel: 715/623-2351. 11tfn/75

THREE YOUNG FAMILY PHYSIcians need fourth man in college community of 80,000 in Southeastern Wisconsin. Two general hospitals with a total of 700 beds. Salary and fringe benefits first year—partnership thereafter. Contact Dept. 421 in care of the journal. 9tfn/74

MEDICAL FACILITIES

PHYSICIAN — INVESTOR/OCCUpants wanted for new medical building in Northridge Shopping Center, Milwaukee. Call Dr Edwin Bercovici at 414/354-2360 or Dr Michael Weinstein at 414/354-5360. 12/76,1/77

OFFICE SPACE AVAILABLE: whole floor 3400 sq ft or part of floor for smaller office is desired. Will divide and remodel to your choice. Located in downtown Milwaukee, 174 West Wisconsin Ave. Convenient to all transportation and expressways. Parking garage in rear of building. Suitable for professional offices. Medical or dental laboratory facilities could be developed. Reasonable rent, long term lease if desired. Contact: Jay N Bhore, MD, 414/765-0225 or Patrick Meade, 414/276-1920. 7-12/76, 1-6/77.

FOR SALE — BY DOCTOR'S estate, medical equipment, fixtures, and furniture. Including some lab equipment. Includes cabinets, examination room equipment, and medical fixtures. Contact: Dorothy Burpee at 502 Barberry Lane, Edgerton, Wis or call 608/884-8721. gtfn/76

OFFICE FOR RENT; 5232 W Oklahoma Ave, Milwaukee. Over 600 square feet. Three examination rooms, very large waiting room. Convenient location (bus stop at front door). Attractive low-rise building. Easy on-street and off-street parking. Available now. Tel: 414/476-4666. 12tfn/76

MISCELLANEOUS

ST THOMAS, VIRGIN ISLANDS. Completely furnished condominium, air conditioned, fully equipped kitchen, ocean view, beach, pool, tennis. Sleeps 2-4 persons. $210 per week. Call 414/257-5568. 1/77

CME Announcements

CONFERENCES FOR MEDICAL PROFESSIONALS.

Over 500 listings of national/international meetings, conferences and seminars in the medical sciences for 1977. Send a $10.00 check or money order payable to Professional Calendars, PO Box 40083, Washington, DC 20016. p1-6/77

PUBLICATIONS

Prescription Drugs and Health Care

A statement by Eli Lilly and Company on Important health-care issues
Revised January, 1976

This 34-page, 8½x11, White Paper has been received in the WMJ office and is available on loan to anyone wishing a resource on health-care information, including the role that prescription drugs play in today's health-care delivery system.

The American Medical Association —Working for a Healthier America

A new AMA publication developed for the general public and replaces an earlier version, *The Little-Known Story of How America's Physicians Work Together to Improve Your Health,* that has been distributed since 1974.

This pamphlet will be particularly helpful to state and county medical societies in responding to letters from the general public or for use as a handout in replying to such letters. It also will be helpful to physicians, staff, or Auxiliary members who wish to describe the diverse activities of organized medicine in talks to civic or other community audiences.

Distribution might be considered for local school systems and public libraries. Consult the Communications Dept of the State Medical Society of Wisconsin.

Additional copies are available at no charge in reasonable quantities. Direct orders to: Order Handling, AMA Headquarters, asking for the publication either by its title or its code number, COMP 43.

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Going Sane. By Joseph Hart, PhD; Richard Corriere, PhD; and Jerry Binder, PhD. Dell Publishing Co, Inc, 1 Dag Hammarskjold Plaza, 245 East 47th St, New York, NY 10017. 1976. Pp 472. Price: $4.95.

Pain: A Personal Experience. By J Blair Pace, MD. Nelson-Hall Inc, Publishers, 325 W Jackson Blvd, Chicago, Ill 60606. 1976. Pp 163. Price: $7.95.

Capitol Hill Manual. By Frank Cummings. The Bureau of National Affairs, Inc, Washington, D C. 1976. Pp 331. Price: $17.50.

National Health Insurance and Income Distribution. By Rita M Keintz. Lexington Books, D C Heath & Company, Lexington, Mass. Pp 218. Price: $16.00.

Acute Diarrhoea in Childhood. Ciba Foundation Symposium 42. CIBA Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1976. Pp 375.

Medical School Admission Adviser. By Marvin Fogel MD and Mort Walker, DPM. Hawthorn Books, Inc, 260 Madison Ave, New York, NY 10016. 1976. Pp 264. Price: $5.95.

Social Responsibility: Journalism, Law, Medicine. Vol II. Edited by Louis W Hodges. Washington and Lee University, Lexington, VA 24450. 1976. Pp 104. Price: $2.50.

Understand Arthritis and Rheumatism. By Malcolm I V Jayson, MD and Allan St J Dixon, MD. Dell Books Publishing Co, Inc, 1 Dag Hammarskjold Plaza, 245 E 47th St, New York, NY 10017. 1976. Pp 234. Price: $1.75.

Current Obstetric & Gynecologic Diagnosis & Treatment. By Ralph C Benson, MD and associate authors. Lange Medical Publications, Drawler L, Los Altos, Calif 94022. Pp 911. Price: $16.00. ■

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 9, 1976.

AMERICAN MEDICAL ASSOCIATION
Continuing Medical Education AWARD

CATEGORY 4

Papers, Publications, Books and Exhibits

There is a limit of 40 credit hours for Category 4.

Ten credit hours may be claimed for a paper, publication or for each chapter of a medical or medically related book that is authored and published. A paper must be published in a recognized medical journal. The definition of a recognized medical journal is one that is published by an organization which requires a medical or medically-related degree for membership, or which has a readership that is made up of a majority of physicians or the allied health professions. A paper that is presented or an exhibit that is shown must be to a professional audience, such as allied health professionals and/or physicians. Credit may be claimed only once for the scientific information presented. Credit should be claimed as of the date materials were presented, published or the exhibit shown.

Medical editing cannot be accepted in any category of credit for the PRA.

* * *

The *Wisconsin Medical Journal* and the preparation/presentation of scientific exhibits at the Annual Meeting of the State Medical Society of Wisconsin are acceptable under this category. (The Annual Meeting Scientific Program of SMS is accredited for Category 1).

Family Physicians

TELEMARK SYMPOSIUM

Tues-Thurs, February 8-10

Mt Telemark, Cable, Wis

14th Annual Symposium and Ski Outing sponsored by the Indianhead Chapter of the Wisconsin Academy of Family Physicians.

A faculty from Mayo Clinic, Rochester, Minn, will present the three-day scientific program. The meeting has been accepted for six (6) hours of prescribed credit by the AAFP.

The meeting is open to all physicians. There is a $20 registration fee for Academy members ($30 for nonmembers). The registration fee may be paid at the door. Those attending should make their own reservations by contacting Telemark Lodge, Cable, Wis. (715/798-3811)

Further information: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

1977 WISCONSIN

Feb 4-5: *Workshop in Rheumatology*, Wisconsin Center, Madison. (See details in box elsewhere in this section.)

Feb 8-10: 14th Annual Symposium and Ski Outing sponsored by Indianhead Chapter of Wisconsin Academy of Family Physicians, at Mt Telemark, Cable. (See details in box elsewhere in this section.)

Feb 10-18: Fifth Annual Postgraduate Endoscopy Course in the Canary Islands, Spain. Sponsored by Medical College of Wisconsin, Dept of Medicine, Milwaukee. (See further details in August issue of WMJ.)

Feb 11: "Current Concepts of Chronic Pain Management," at Winnebago Mental Health Institute, Winnebago, Wis. Acceptable for 4 credit hours. Info: Steve Kearney, Director of Educational Services, Winnebago Mental Health Institute, Box H, Winnebago, Wis 54985. Tel: 414/235-4910, ext 316.

Feb 17: In-depth teaching program: "Emergency Treatment of Head Injuries" at Madison General Hospital Info: William Wendle, Coordinator Continuing Medical Education, SMS office. Tel: 608/257-6781.

Feb 19: Continuing Education Course on Cardiac Radiology, Veterans Administration Center, Wood, Wis. Four hours Category I Credit AMA-PRA. Info: Thomas J Imray, MD, Dept of Radiology, Milwaukee Medical Complex, 8700 W Wisconsin Ave, Milwaukee, WI 53226.

Feb 18-19: *Workshop in Rheumatology*, Sacred Heart Hospital, Eau Claire. (See details in box elsewhere in this section.)

Feb 25-26: *Workshop in Rheumatology*, Wood VA Center, Wood. (See details in box elsewhere in this section.)

Mar 23-30: Medical College of Wisconsin's 10th Annual Postgraduate Course in *Gynecological Pathology, Cytogenetics, and Endocrinology*, at the Pfister Hotel and Tower, Milwaukee. Info: Charlotte Templeton, Course Coordinator, Dept of Gyn-Ob, MCW, 8700 West Wisconsin Ave, Milwaukee, Wis 53726; ph 414/257-5580.

Apr 22-23: *Symposium on Critical Care Medicine*, sponsored by the Wisconsin Society of Critical Care Medicine, at Lutheran Hospital, Milwaukee. Info: Shirley Hagen, Executive Secretary, 700 North Water St, Milwaukee, Wis 53202.

Apr 30: One-day symposium on *Basic Sciences and the Clinical Practice of Anesthesia*, at Hoffman House-Midway Motor Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

May 25: One-day symposium on *Office Dermatology* 1977, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

1977 AMA

Feb 4-6: "The Impaired Physician: Answering the Challenge," Atlanta, Ga, Hyatt Regency Atlanta.

Mar 30-Apr 1: 30th National Conference on Rural Health, Seattle, Wash, Washington Plaza.

Jun 18-22: AMA Annual Meeting, San Francisco, Calif, Fairmont Hotel and Tower; San Francisco Convention Center—Brooks Hall.

Aug 8-13: "Medinfo '77"—2nd International Conference on Medical Computing, cosponsored by the Canadian Medical Association, International Federation for Information Processing; and World Health Association.

THE IMPAIRED PHYSICIAN: ANSWERING THE CHALLENGE

Sponsored by American Medical Association and the Medical Association of Georgia

Feb 4-6: Hyatt Regency Hotel Atlanta, Georgia

Feb 4: Overview of the Problem of Impaired Physicians
Comparative Analysis of Impaired Physician Programs Established by Medical Societies, Hospitals, Licensing Boards and Other Groups

Feb 5: Panel on Problems and Techniques of Casefinding
Concurrent Workshop Sessions

Feb 6: Summary of Workshop Sessions
Informal Post-Conference Discussion Groups

Attendance qualifies for Category 1 credit toward the AMA Physician's Recognition Award.

Info: AMA Department of Mental Health
535 North Dearborn Street
Chicago, Ill 60610

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Dec 20-23: AMA National Leadership Conference.

Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

1977 OTHERS

Feb 4-6: *The Impaired Physician: Answering the Challenge*, Atlanta, Ga, Hyatt Regency Atlanta. (See details in box elsewhere in this section.)

You are invited to participate in a symposium entitled

STROKE
Modern Trends in Cerebrovascular Disease

THE DIPLOMAT HOTEL
HOLLYWOOD, FLORIDA

Feb 9-12, 1977

A distinguished faculty of internists, neurologists, and surgeons will present the latest in stroke care

For information write:

Mr Ronald A Nelson
Executive Director
American Heart Association
Broward County Chapter
440 North Andrews Avenue
Fort Lauderdale, Florida 33301

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

January 24—February 6

Differential Diagnosis of Oral Lesions, with Maurice Galante, MD, Associate Professor of Surgery, School of Medicine; Sol Silverman Jr, DDS, Chairman and Professor of the Division of Oral Biology, School of Dentistry; both at the University of California, San Francisco.

Low Back Pain—Chronic, with Peter Marchisello, MD, Chief, Back Clinic, Hospital for Special Surgery, New York City.

Drug Spotlight: Antiarrhythmic Drugs, with Edmund H Sonnenblick, MD, Professor of Medicine, and Chief of the Cardiology Division; William H Frishman, MD, Director of Noninvasive Cardiology; both at the Albert Einstein College of Medicine, New York City.

February 7—February 20

Spinal Cord Trauma, with Alain B Rossier, MD, Chief of Spinal Cord Injury Service, Veterans Administration Hospital, W Roxbury, Mass, Professor of Spinal Cord Rehabilitation at Harvard Medical School, Boston.

Antibiotics in Renal Failure, with Harold C Neu, MD, Associate Professor of Medicine, Associate Professor of Pharmacology, and Head of Section on Infectious Diseases, College of Physicians and Surgeons, Columbia University, New York City.

Benign Prostatic Hyperplasia, with Earl Wendel, MD, urologist, Passavant Hospital, Chicago.

February 21—March 6

Anaerobic Infections, Part 1, with Robert Fehety, MD, Head Division of Infectious Diseases, Department of Medicine, University of Michigan, Ann Arbor.

Anaerobic Infections, Part 2, with William J Ledger, MD, Professor of Obstetrics and Gynecology, University of Southern California, and Director of Maternal Fetal Medicine at Women's Hospital, Los Angeles.

Carcinoma of the Prostate, with Earl Wendel, MD, urologist, Passavant Hospital, Chicago.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in most videotape and videocassette formats.

Mar 2-5: Thirty-third Annual Midwest Clinical Conference, at McCormick Inn, 23rd and the Lake, Chicago, Ill. Sponsored by Chicago Medical Society with participating Chicago specialty societies. Info: Chicago Medical Society, 310 S Michigan Ave, Chicago, Ill 60604; ph 312/922-0417. 1-2/77

Mar 11-17: Twelfth Annual Marquette-MCW Medical Alumni Association Clinical Conference, Mullet Bay Beach Hotel, Island of St Maarten, in the Caribbean. Four-day scientific program, six full hours a day, qualifies under new IRS regulations for overseas conventions. Full-time faculty from Medical College. All physicians invited to attend (you don't have to be an alumnus). For further information contact: Marquette-MCW Medical Alumni Association, 561 N 15th St, Milwaukee, Wis 53233. Phone 414/257-8200. 1-2/77

CONTRIBUTIONS—CES FOUNDATION
November 1976

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for November 1976.

Unrestricted

2 SMS Members—*Voluntary contributions*

Restricted

2 SMS Members—*Student Loans*
1 SMS Member—*Other Than CESF Projects*
1 SMS Member—*Continuing Medical Education*
Membership Dues—*Aesculapian Society; Academy of Medical History*

Memorials

Mrs Mather Pfeiffenberger—*WB Hildebrand, MD (Hildebrand Memorial Fund)*
Dr-Mrs Robert T Schmidt—*Lawrence Gilling, DDS; James F McCormack; Lawrence Popp, DDS (Brown County Loan Fund)*
Dr-Mrs WW Grover—*Mrs John Harker*
Dane County Medical Society—*John R Newman, MD* ■

Workshop in Rheumatology

For primary physicians, registered nurses, occupational therapists, and physical therapists.

Presented by The Department of Continuing Medical Education, Health Sciences Unit, University of Wisconsin-Extension, and the Center for Health Sciences, University of Wisconsin-Madison.

In cooperation with Wisconsin Regional Medical Program, Inc and the Arthritis Foundation of Wisconsin.

February 4-5
Wisconsin Center, Madison

February 18-19
Sacred Heart Hospital, Eau Claire

February 25-26
Wood VA Center, Wood

Two-day program presenting practical aspects of the diagnosis and management of patients with rheumatoid disease, focusing on rheumatoid arthritis and hyperuricemia.

Conference fee: $7.00. Physician Credit: AMA—nine hours of Category 1; AAFP—nine hours of credit. All participants—nine Continuing Education Hours (CEHs).

For more information and application forms contact: Outreach Coordinator, Gary Greene, Room 465 WARF, 610 North Walnut St, Madison, Wis 53706; 608/263-2857.

Television Programs
Spotlight Pediatrics

The Wisconsin Chapter of the American Academy of Pediatrics is sponsoring a series of 12-30 minute television programs titled, "An Ounce of Prevention," over the ETVN statewide network. These are programs for parent and patient education covering a broad range of pediatric subjects.

WMVS-TV (Ch 10) Milwaukee will air the program on Friday at 3:00 pm, repeat the same program at 9:00 am on Saturday beginning January 14-15, 1977.

The other ETVN stations viz WHA-TV (Ch 21), Madison; WHLA-TV (Ch 31) LaCrosse; WHWC-TV (Ch 28) Menomonie/Eau Claire; WHRM-TV (Ch 20) Wausau; and WPNE-TV (Ch 38) Green Bay, will air the programs on Friday at 6:00 pm beginning on January 21.

A thirteenth program will present local Wisconsin pediatricians and a station host. They will answer questions received from the viewing audience during the series.

Further information: University of Wisconsin Department of Continuing Medical Education, 610 Walnut Street, Madison, Wis 53706; 608/263-2850.

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings

1977-1987

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel.

1977—April	**14-16**
1978—April	**13-15**
1979—May	**10-12**
1980—March	**27-29**
1981—March	**26-28**
1982—April	**15-17**
1983—March	**24-26**
1984—March	**29-31**
1985—March	**28-30**
1986—April	**17-19**
1987—March	**26-28**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Dates 1977 through 1981 have been approved by House of Delegates action; dates 1982 through 1987 have been tentatively approved by Council action and will be reviewed and acted on by the House of Delegates.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

COPYRIGHT. Material that is published in the WISCONSIN MEDICAL JOURNAL is protected by copyright and may not be reproduced without written permission of both the author and the JOURNAL. However, most state and regional medical journals owned by state medical societies have granted each other continuing copyright permission to copy or quote with proper credit. Copyright permission is not granted to commercial or privately owned publications.

RESPONSIBILITY. Publication of the WISCONSIN MEDICAL JOURNAL is under the direction of the Editorial Board whose policies are approved by the Council of the State Medical Society of Wisconsin. The Medical Editor is chairman of the Editorial Board. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production and business operation of the JOURNAL, as well as final responsibility of the entire publication.

Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

ADVERTISEMENTS. The acceptance of advertising in the WISCONSIN MEDICAL JOURNAL is predicated on the basis that the advertised product or service meets the ethical principles established by the Council of the State Medical Socity of Wisconsin. The JOURNAL reserves the right to accept or reject advertising copy for any reason. Advertising rates will be furnished on request.

CIRCULATION. Members of the State Medical Society of Wisconsin receive the WISCONSIN MEDICAL JOURNAL each month. The cost of the Journal for members ($5.00 per year) is included in dues. Non-members may subscribe at the following rates: $10.00, one year; $1.50, single copy; $3.00, previous years; $5.00, Annual Blue Book. The JOURNAL reserves the right to control its circulation.

INDEXING. The WISCONSIN MEDICAL JOURNAL is indexed in "Index Medicus" and "Hospital Literature Index," and its contents page appears regularly in "Current Contents/ Clinical Practice." ■

PRINCIPLES OF ADVERTISING

Wisconsin Medical Journal

The acceptance of advertising in the *Wisconsin Medical Journal* is predicated on the basis that the advertised product or service meets the ethical principles established by the Council of the State Medical Society of Wisconsin. The Journal reserves the right to accept or reject advertising copy *for any reason.*

The following general rules are applicable to advertisements of medicinal preparations, apparatus or physical appliances or other products for therapeutic or diagnostic purposes or for which therapeutic, diagnostic or health claims are made:

1. The advertiser may be required to submit evidence or data in support of the usefulness of the product and the validity of the claims. The appearance of one or several papers may not necessarily be considered sufficient evidence and other data may be required.
2. Medicinal preparations containing two or more active ingredients will be considered only if in the opinion of the Advertising Committee of the Bureau there is a logical rationale for the inclusion of each active ingredient, and if a statement of the active ingredients is included in each advertisement.
3. The generic or official designation of the medicinal preparation must be adequatey featured in advertising copy, in addition to the trade name.

All advertising copy is subject to the following general rules:

1. Advertisements should not be false, deceptive or misleading nor make use of sweeping superlatives.
2. Unfair comparisons and disparagment of a competitor's goods will not be allowed.
3. When excerpts from a published paper are included in advertising copy, the Bureau may require the advertiser or his agent to obtain written permission from the author and from the editor or publisher of the publication in which the paper appeared.
4. Advertising copy will not be accepted if, in the opinion of the Bureau or the management of the medical journal, the copy (a) appears to violate the Principles of Medical Ethics of the American Medical Association or of a state medical association, (b) is indecent or offensive in any way, (c) contains attacks of a personal, racial or religious character, or (d) appears to be contrary to any regulation or law for the prevention of discrimination, or (e) contains claims found by any court or federal or state agency to be invalid or in violation of law.
5. Advertisers and advertising agencies agree to protect and indemnify both Bureau and any medical journal represented by Bureau against any and all liability, loss or expense arising from claims for libel, unfair competition, unfair trade practice, infringement of trade-marks, trade names or patents, copyrights or proprietary rights, violations of rights of privacy and any other claims resulting from any advertisement submitted to the Bureau or published in any such medical journal.

The foregoing principles may be changed at any time without notice.

"Bureau" as used above refers to the State Medical Journal Advertising Bureau, Inc., Oak Park, Illinois.

NEWS YOU CAN USE

DURABLE MEDICAL EQUIPMENT MANUALS PRINTED

WPS has mailed to all physicians' offices the first Medicare Part B *Durable Medical Equipment Manual.* The manual has a screening list for durable medical equipment as well as the medicine coverage status of the equipment. Durable medical equipment is defined as that equipment which "can withstand use and is primarily and customarily used to serve a medical purpose and generally is not useful to a person in the absence of an illness or injury; and is appropriate for use in the home." WPS asks physicians to look through and become familiar with the manual. Also, to assure proper and prompt payment, physicians are asked to pay special attention to the sample claim and prescription forms shown in the manual. Strict adherance to the booklet and sample forms will speed payment and eliminate unnecessary correspondence between WPS and physicians. The manual also indicates the necessary information physicians must include on prescription forms for Medicare patients needing durable medical equipment. The prescription must contain (1) diagnosis, (2) prognosis, (3) reason equipment is required, (4) estimated time period equipment will be needed, and (5) name and address of the prescribing physician.

Once a physician determines the equipment medically necessary and writes a prescription, it is the patient's decision as to whether the equipment will be rented or purchased. Equipment may be purchased from a medical equipment supplier or a private individual. Inexpensive items ($50 or less) will be paid for in a lump sum while items over $50 will be paid for in monthly installments equivalent to the amount the payment would be if the equipment were rented. In those cases where monthly payments are made, notice will be sent to the prescribing physician and beneficiary in advance of the date payments will be stopped. This will eliminate the unnecessary stopping of payments in those cases where continuing medical need can be established. In the event that equipment is purchased prior to the entitlement of Medicare the entire cost will be denied.

Physicians' offices are asked to keep the *Durable Medical Equipment Manual* handy and use it as suggested. The manual will be updated in future issues of a WPS publication called *COMMUNIQUE* which will detail the necessary corrections, deletions, and additions.

DON'T WASTE MONEY . . KEEP GOOD RECORDS

It pays, in both time and money, to keep good records, especially good records of your drug purchases. It was recently learned that drug companies are required to supply the Federal Drug Enforcement Administration (DEA) with copies of purchase orders which deal with drug sales to physicians. These purchase orders are then screened by DEA and any unusually high amount of drug purchases are reported to the Wisconsin Medical Examining Board for further investigation. This is how the Medical Examining Board was tipped off in its current investigation of about 25 physicians for alleged drug abuse tactics. The Board will first hold informal (closed) hearings to allow those physicians under suspicion to explain their drug buying habits. If that explanation is acceptable, then the matter will be dropped. If further investigation is necessary, then the Board will hold formal (open) hearings. A spokeswoman for the Medical Examining Board says that normally hearings will not proceed beyond the informal stage since most physicians do have good reason for the large purchases. She stressed the best defense a suspected physician can have is a complete set of records to show the Board.

NOTIFY WPS OF CHANGES IN SPECIALTY OR CERTIFICATION

Physicians are reminded that it is to their advantage to keep WPS informed about any changes in their specialty status or certification. For the purposes of proper reimbursement under government contracts (T-18, T-19, and CHAMPUS), physicians should notify WPS regarding any change in their status. Direct information to WPS, 1717 West Broadway, Madison, Wis 53713. Mark the correspondence: ATTN: CPCU, and include the phone number. ▪

FRONT PAGE—UPDATE

LATEST ON THE MEDICAID FEE FREEZE

The SMS lawsuit against the State Department of Health and Social Services (DHSS) demanding an end to the illegal Medicaid fee freeze has been assigned to a new court, that of Dane County Circuit Court Judge P Charles Jones. A pretrail date has been set for April 5.

PRIOR AUTHORIZATION FOR AMPHETAMINES

The State Medical Society has asked DHSS to reconsider its announced policy of prior authorization for amphetamine prescriptions for Medicaid patients. The policy, effective February 1, requires physicians to telephone or write DHSS in Madison before prescribing amphetamines for Medicaid patients. DHSS Secretary Manuel Carballo said the new policy results from findings by the State Controlled Substances Board of "possible links" between the abuse of controlled substances and Medicaid billings. Society President Charles Picard, MD, Superior, protested the policy, writing DHSS Secretary Carballo, "The requirement of prior authorization is a restriction which may pose hazards to patient care and markedly increase the cost of service for those with medical need."

PSYCHOTHERAPY AUTHORIZATION?

DHSS also has proposed two other programs of prior authorization for treatment of Medical Assistance patients. The Department held a public hearing in Milwaukee last month for an administrative rule which would require prior authorization from DHSS in Madison for psychotherapy services for a Medicaid patient. An SMS position paper filed at the hearing blasted the proposal, commenting, ". . . we believe government legislators and administrators are exceeding their legal and moral responsibilities when they impose themselves between the physician and the patient. We can find no rationale whatsoever for allowing a DHSS employee, who has never seen the patient or his/her record, to make some serious decisions about that patient's care." The proposal drew heavy criticism; it will now go to the Legislature for review.

THE LATEST ON DRUG SUBSTITUTION

DHSS Secretary Manuel Carballo proposed in late December 1976 that physicians be required to telephone or write DHSS in Madison before writing NS or no substitution on any prescription for a Medicaid patient. The State Medical Society strongly opposed the proposal, pointing out that the primary issue in the drug substitution law, for a Medicaid patient or anyone else, is proper care for the patient, and that only the physician should have the responsibility for determining if a drug substitution is in the patient's best interests. Society staff members met with Secretary Carballo and his staff, and Carballo agreed to drop the idea. In return, the Society agreed to (1) set up a monitoring survey to determine the use of NS under the Medicaid program; and (2) continue efforts among physicians to encourage generic prescribing and dispensing where this is consistent with quality care for the patient, and to assist in cost containment. Society representatives pointed out that SMS has long backed the concept of drug substitution, and in fact, wrote the legislation and helped move it through the Legislature.

PHYSICIAN ETHICS IN CRIMINAL INVESTIGATIONS

The SMS Council has recommended to state officials that no person employed as the personal physician for an inmate of a correctional institution be required to act as an officer of the law; that is, that another physician be employed for all personal body searches. This action followed reports of a State Division of Corrections policy for body cavity searches for prison medical personnel. A Wisconsin physician had contacted the Society, pointed out that searches for drugs create a serious credibility gap between the physician and the inmate-patient. ■

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The Profession of Psychology as Prototype

THE PHYSICIANS of this state have been only partly aware of the activities, over the past decade, of numerous ancillary groups moving directly toward autonomy. Psychology is only one example; but while psychologists are pushing toward both professional and financial self-sufficiency, it could behoove our Society to at least notice that other groups concerned with health care and delivery are moving out from under our presumed medical control.

Using psychologists as an example there has been organized now a "Division One, The Division of Clinical/Consulting Psychology, of the Wisconsin Psychological Association." They ask of their members $150 per year, which they state is tax-deductible as a business expense; they offer in return political activity to help define psychological services within the state, escape from prescription by physicians for psychological services, and offer access to the "best legal opinion to determine the most logical points of entry into Wisconsin Law."

Now this is not so unusual on the face of it, but for a moment extend the principle to all of medicine. Already there is a legal battle beginning on the subject of paying physicians directly, or not, for services performed by nurses and physician assistants; even a cursory reading of the Medicare information will illustrate this. Certainly some precise and detailed judgments can be made, beneficial to all concerned: physicians, ancillary persons, the public, and the body politic; for example, there is no justification for demanding supervision of qualified psychologists by general physicians lacking in psychiatric training. But a disparity like this can be solved far short of total autonomy, for either professional group.

Last month on these pages the American Psychiatric Association's definition of "psychotherapy" was quoted, for example. It would seem reasonable for physicians, both generalists and specialists, to similarly define their essential professional function. If this is not done, then the number of sub-specific groups capable of making definitions and making them stick will no doubt surprise some. It just is not enough to depend upon good will and good works alone; some of us have practiced this way over many years only to see the slightest nuance in a definition change long-established practice patterns.—RH

Continuing Medical Education Continues

WHILE THERE is still uncertainty as to just what number of hours of continuing medical education will be required, and by whom will they be required, there has been no such uncertainty about programs to satisfy the need. At least three days per week most physicians find a brochure in their mail boxes offering one or another form of Category I education. In my field I received just the other day the offer to attend, for one hour of Category I credit, a lecture on "The Use of Transactional Analysis with Music Therapy." Interestingly there seems to be no restriction on what is taught, only that the presenting bodies (Societies, Associations, Departments of Medical School) make a formal plan to limit their presentation to a specific topic. And so far at least I could take all my required hours on hypertension, or electrolyte balance (assuming of course no examination be given, as is often true).

The problem of certifying clinical competence is extraordinarily difficult; some aspects of this have already been commented on in this column. Now we must be sure, if indeed CME is to be the forum, that it not become (a) too loosely defined related to practice, (b) reasonably educational rather than redundant, and (c) not so esoteric either in content or location as to strain credibility.—RH

The Forgotten Patient

THERE IS a forgotten patient hidden in the awesome complexities of the modern general hospital. It is the lonely figure struggling with a terminal illness. Certainly there is no area of medicine in which I for one feel more ill at ease. Once the cancer has demonstrated its metastases, and chemotherapeutic efforts have failed, a strange performance begins. Physicians, nurses, clergy, family, even the patient play their roles. The inane questions begin: "How are you feeling today?" "Did you finish your lunch?" "How did you sleep last night?" "Did the nurse take you for a walk?"

How alone the patient must feel in this crowd of pretenders. No one ever looks him straight in the eye and addresses the heart of the problem; at least not until recently in this part of the country.

Happily, Waukesha Memorial Hospital's staff has formed a Committee on Death and Dying. It is made

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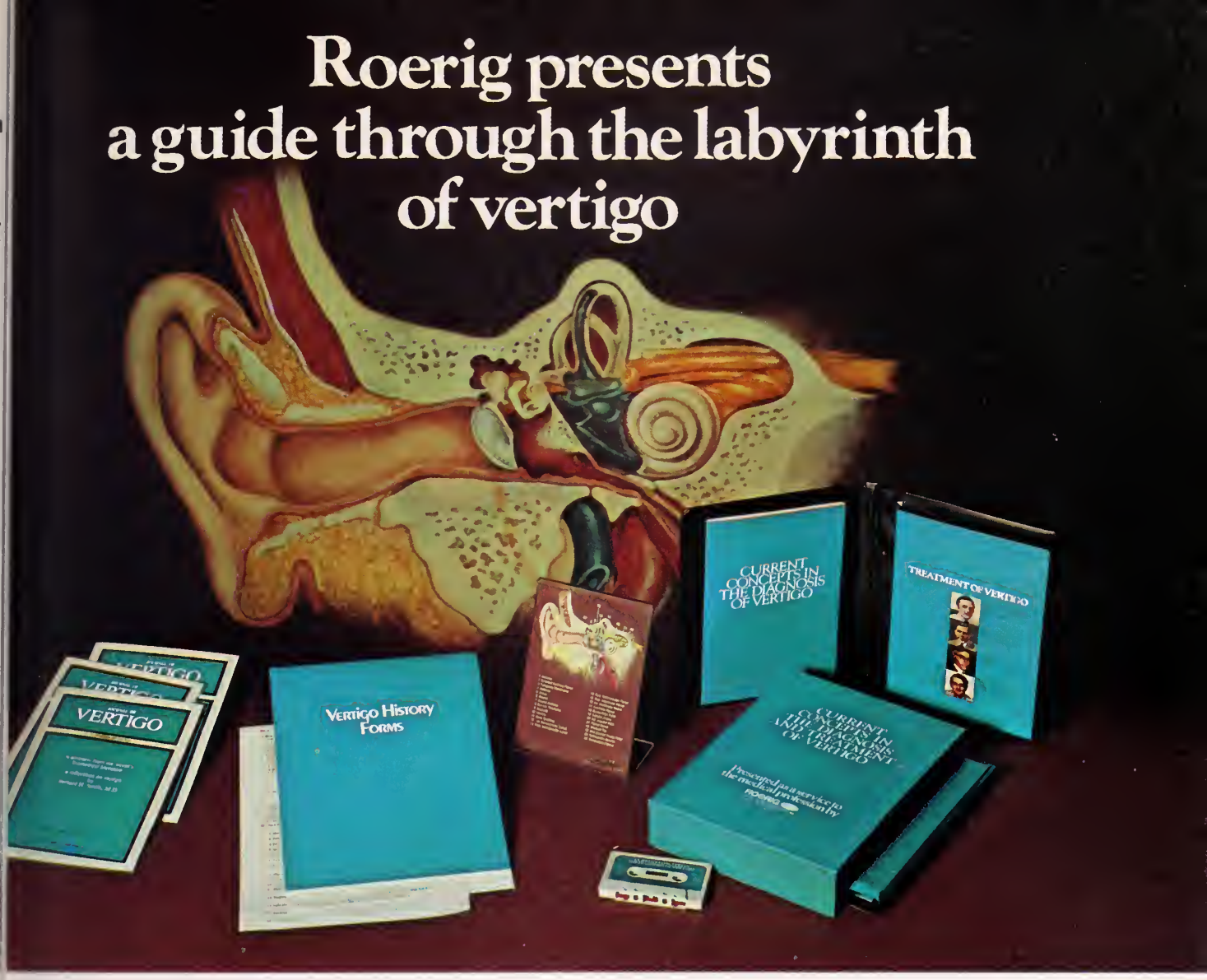
Roerig presents a guide through the labyrinth of vertigo



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STOP THE SILENT EPIDEMIC

Volumes have been written upon the topic of hearing loss—yet over 11.5 million Americans suffer from uncorrected hearing problems. Why, with modern medical treatments and the latest hearing aid technology, hasn't more been done to help the hearing handicapped. The reasons are numerous. Hearing loss has been equated with old age, loss of virility, even ignorance. The major problem, however, is people don't know what to do or where to go. Unfortunately, the consuming public has been deceived over a period of years by misleading advertising, dishonest salespersons, well meaning, but inaccurate and usually inconsistent reports which make blank condemnation of all efforts associated with corrective amplification. The facts are that most people suffering from hearing loss can be helped—medically, surgically, or with corrective amplification.

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up of a diversity of concerned individuals. Only one other hospital in the Greater Milwaukee Area has made any effort in this direction. The Waukesha group has understandably experienced a few minor uncertainties, but it has made a brave start. It has met with several patients, always with the personal physician's approval and the patient's understanding that the service is without charge. Some of the patients are shy and hesitant, others have released a torrent of pent-up fears. Some have been deeply grateful. None have been resentful.

We're spending endless time and uncountable millions medically attending to a vast army of anxiety ridden, anatomically healthy individuals. It's time some of this money and effort was directed toward the hopelessly ill patient.

We've got to stop the charade. We must look at the patient directly, and gently but honestly tell him that we cannot cure him. We must promise, then, to do everything we can to keep him comfortable, to preserve his dignity, to answer his every question, and most importantly never desert him. A patient, when he's dying, needs more than a physician. He needs a friend. A serious Committee on Death and Dying can fill a real void.—T H McDonell, MD, Waukesha.

Swine Flu—Fiasco and Aftermath

The proposed massive flu immunization program got off to an inauspicious beginning with prolonged production problems. This was followed by months of legal and congressional wrangling about assumption of liability. (Current suits against the government range from $9 to hundreds of thousands of dollars). At last the innoculations were actually begun after reams of confusing and often irresponsible publicity. Then came the blaring headlines that the "shots had caused" a number of deaths in the elderly. There was, of course, no parallel count of the deaths among the uninnoculated in the same age group who simply ran out their life spans at that same time.

Two cases of swine flu were isolated in Wisconsin. This resulted in a brief impetus for the swine flu clinics. The final blow to the ill-starred program was the incidence of several cases of Guillain-Barré syndrome. Although the syndrome has occurred in the past after other types of innoculations—and in many instances without antecedent vaccination—the entire program was discontinued.

The sad aftermath to this well-intentioned swine flu program is that it will be extremely difficult, if not impossible, to mount a mass innoculation program in the future as long as anyone remembers the swine flu fiasco. Even worse is the inevitable damage to the routine immunization program for infants and children. Public health officials report that the percentage of adequately immunized children is decreasing and that there could be a resurgence of diseases such as polio which had been practically eliminated. That would be a tragedy!—VSF ■

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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Vital Records Certificates to Require Black Ink Entries

To the Editor: Hidden away in the archives of the State Office Building are two women who spend most of their days tracing over colored ink entries, or faded typewriter ribbon entries on certificates of birth, death, marriage, divorce and fetal death.

A few steps away one may find another bureau employee making a second, third, fourth, or even fifth photocopy of a certificate, trying to coax from the machines one good copy of a poor quality record.

The amount of waste in manpower and machine costs is very difficult to justify to taxpayers in these times of budget trimming and enforced cost savings. And in an age when the consumer is becoming more service conscious, it is not easy to explain the issuance of certified copies that are hardly readable.

All vital records are completed by professional people or by personnel in institutions for which professional people are responsible. Since the issuance of complete and satisfactory certificates is required by State Law (SS 69.06), this should be considered a part of the service for which the professional receives his fee.

Beginning February 1, 1977, therefore, the office of the State Registrar will begin alerting local offices that certificates are of poor quality whenever ink other than black is used or whenever a worn typewriter ribbon results in a poor quality record.

After May 1, 1977, poor quality records will no longer be accepted by the State Registrar. They will be returned to the local office and it will be the responsibility of the local Register of Deeds (or Clerk of Courts in the case of divorce certificates) to obtain a satisfactory record.

RAYMOND D NASHOLD, PhD, *Director*
Bureau of Health Statistics
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More on Council Activity

In addition to those items reported in FRONT PAGE UPDATE and NEWS YOU CAN USE, the SMS Council dealt with a lengthy agenda at its January 15 meeting in Madison.

WHCRI-WisPRO Relationship

The Council examined the relationship between Wisconsin Health Care Review, Inc (WHCRI) and Wisconsin Professional Review Organization (WisPRO).

WHCRI is a statewide multi-disciplinary review organization, created by the SMS House of Delegates in 1971, which currently conducts an Independent Medical Review Program in Wisconsin.

WisPRO is the federally mandated Professional Standards Review Organization (PSRO) for all counties outside southeastern Wisconsin, and it is a component of WHCRI.

A special Council committee recommended, and the Council voted, to request that WHCRI immediately take all steps necessary to separately incorporate WisPRO with the boards of directors of the two organizations merged or overlapping to the extent feasible and allowed by federal law; that the corporate bylaws of each be as identical as possible, with non-PSRO-mandated programs executed under the policies established by WHCRI, with a single staff to serve both corporations.

The Council's action seeks to coordinate both governmental and private sector review, but with the latter free from policy control or influence by the government.

Both WHCRI and WisPRO administrative offices are located at the SMS headquarters building in Madison.

Public Policy Symposium

The Council agreed that it will co-sponsor a one-day symposium with the Wisconsin Center for Public Policy. This symposium will deal with specific key state policy initiatives, including health policy.

Evaluation of Delivery and Cost of Medical Care

The Committee on Evaluation of Delivery and Cost of Medical Care reported four target areas for committee activity in the coming year. They include: (1) identifying cost areas that are within control of the physician; (2) evaluating the structure and operation of current and proposed relative value systems; (3) studying the distribution of physicians, and the influence of costs and income on that distribution; and (4) determining the relationship of office practice to hospital practice in terms of cost.

WPS 1976 Financial Results

The Wisconsin Physicians Service (WPS) reported its 1976 financial results, which show that reserves are in excess of $14.2 million. Budget forecasts for 1977 call for a continuing low percentage of premium income allocated to budgeted administrative expense, with 5.7% anticipated. (Since 1970 when budgeted administrative expenses reached 9.9%, this percentage has steadily declined.)

The Council urged the State Group Insurance Board to delay action on a formalized second opinion program until more definitive data are available on its potential cost-savings effectiveness.

The WPS Commission reported it has found its UCR (usual-customary-reasonable) system for claim payment is a workable and effective method of assuring subscribers full coverage, while protecting itself, and ultimately premium payers, from unpredictable and unreasonable fee increases. WPS provided information which showed that the method of UCR determination is not inflationary. In fact, the statistics showed that increases in the UCR payment level have, overall, lagged behind inflation. ■

Capitol Week Initiated

The State Medical Society's Physicians Alliance and Communications Divisions have begun publishing a weekly newsletter during the legislative session, dealing exclusively with political and legislative matters.

Called *Capitol Week*, the communication will go weekly (First Class) to those physicians who have expressed an interest in participating in the legislative contact program.

The newsletter keeps physicians informed about key political-legislative developments, enabling them to contact legislators about particular bills or amendments.

Physicians interested in receiving *Capitol Week* should contact the Physicians Alliance Division at the SMS offices in Madison. ■

SMS Insurance Benefits

For all those physicians who enrolled during the charter enrollment period, the SMS-sponsored accidental death and dismemberment insurance program is now effective. The effective date for coverage for the original applicants was January 1, 1977. ■

You Get What You Pay For!

The editors of *Medical Economics* magazine reported in the January 10 issue that Wisconsin has the highest dues of any of the state medical societies. (*Connecticut Medicine* reported the same set of statistics in its October 1976 issue.)

The report said Wisconsin's annual dues payment of $300 was highest, Tennessee's $80 was lowest, with the average of $161 which was closest to Maryland's dues of $160. But the editors didn't tell the whole story.

The statistical analysis did not include a comparison of services rendered by the state medical societies nor a comparison of economic-geographic factors that also influence such costs. And such a comparison does not take into consideration the number of members served, a significant factor in the total budget of all societies whose functions are basically the same.

As the old saying goes, you get what you pay for.

A major difference between Wisconsin and the other state medical societies is the new Wisconsin SMS approach to dealing with the political/legislative/socio-economic needs of Wisconsin physicians.

continued on page 17

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Here is a complete list of those candidates chosen for top State Medical Society offices by the Committee on Nominations. This is the slate on which the House of Delegates will vote at the Society's Annual Meeting April 14-16 at Milwaukee's Exposition and Convention Center and Arena (MECCA) and Marc Plaza Hotel. Be sure to let your county medical society delegate know your preferences in the next few weeks.

Dr Ray B Larsen
Incoming
President
1977-1978

Dr Levin

Dr Motzel

Dr Taebel

Annual Meeting: Nominees Awaiting the Vote

☐ **Jules D Levin, MD**
President-elect
Alternate Delegate to AMA (1978-79)

Graduate of University of Wisconsin Medical School. Received internship at University Hospitals, Madison, 1938-1939. Served interim residency at Johnston Municipal Hospital, Milwaukee, 1939-1941, and had fellowship in neurological surgery at University of Minnesota, 1941-1944 and 1946-1948. Received license to practice in Wisconsin in 1939. Has practiced neurological surgery in Milwaukee since 1948. Received board certification in neurological surgery in 1951. Is associate clinical professor of neurological surgery at Medical College of Wisconsin. Is fellow of American College of Surgeons and International College of Surgeons. Is member of American Association of Neurological Surgeons (Harvey Cushing Society), Congress of Neurological Surgeons, American Academy of Neurology, Association of Research in Nervous and Mental Diseases, Central Neurosurgical Society, Pan American Medical Society, Pan Pacific Surgical Society, Royal Society of Medicine (London), Milwaukee Neuropsychiatric Society, Milwaukee Academy of Medicine, American Medical Association, State Medical Society of Wisconsin, and Medical Society of Milwaukee County. Was president of Milwaukee Neuropsychiatric Society, 1962-1964, and president of Medical Society of Milwaukee County, 1973. Was a member of board of directors of Medical Society of Milwaukee County, Surgical Care-Blue Shield from 1972-1976, and is a member of Foundation for Medical Care Evaluation of Southeastern Wisconsin, Wisconsin Health Care Review, Inc., Medical Center of Southeastern Wisconsin, and St. Mary's Hill Hospital, Milwaukee. Is counselor of Milwaukee Neuropsychiatric Society. Is trustee of the State Medical Society's Charitable, Educational and Scientific Foundation. Is delegate to the State Medical Society of Wisconsin from the Medical Society of Milwaukee County and alternate delegate to the American Medical Association from Wisconsin. Is on the attending staffs of St. Luke's, St. Francis, West Allis Memorial, Milwaukee Children's, Deaconess, St. Michael's and Family hospitals and of Mt. Sinai Medical Center, and has been chief of neurosurgical service in all of these. Is on the consulting staffs of Milwaukee County General and Johnston Municipal Hospitals and has been on both of their consulting staffs. Is a 32nd degree Mason, a Shriner and a Rotarian. Is member of American Legion and Milwaukee Athletic Club.

☐ **Albert J Motzel, Jr, MD**
Speaker of the House of Delegates

Graduate of St Louis University Medical School. Received internship at Milwaukee County Hospital in 1953-1954 and served residency in surgery at Milwaukee County Hospital in 1954-1958. Received license to practice medicine in Wisconsin in 1954. Has been in practice of general surgery in Waukesha since 1958. Has been a Diplomate of the American Board of Surgery since 1959. Is clinical instructor in surgery at Medical College of Wisconsin. Is on active staff of Waukesha Memorial Hospital, Waukesha, and on associate attending staff of Milwaukee County Hospital, Milwaukee. Is Director of Medical Education at Waukesha Memorial Hospital. Was president of Waukesha County Medical Society in 1972-1973. Has served as delegate from Waukesha County Medical Society to State Medical Society of Wisconsin and has also

You Get What You Pay For! *continued*

In 1975 the SMS established the Physicians Alliance Division to deal aggressively with the Wisconsin Legislature, state agencies, and the federal government, and to protect the patient-physician relationship.

The Division is directed by a 15-member commission appointed by the Council. The Physicians Alliance has five field consultants who meet and talk with SMS members every day.

The Alliance has two full-time lobbyists, experienced in dealing with legislators and agencies, working this session of the Legislature.

The Alliance is headed by an executive director and includes an administrative staff working at SMS offices in Madison.

No other state medical society has launched such a program. No other state medical society has made a similar commitment to the needs of its members. However, this exciting approach also costs money.

Early results of the Physicians Alliance concept are encouraging, particularly the physician participation in the past general and primary elections.

The 1977 SMS operational budget shows that nearly one-third of the dues dollar will support the Physicians Alliance Division. This commitment to the Physicians Alliance concept concurs with the view of an overwhelming majority of physicians who responded to a survey conducted by the Society one year ago. ■

SMS Variable Annuity Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.52626394 as of December 31, 1976. ■

served as an alternate delegate. Is a member of the American Medical Association, Wisconsin Surgical Society, Milwaukee Academy of Surgery, Society for Computer Medicine, and Association for Hospital Medical Education. Is a Fellow of the American College of Surgeons. Is Waukesha County representative to Southeastern Conference of County Medical Societies. Is director and vice-president of Board of Directors of Foundation for Medical Care Evaluation of Southeastern Wisconsin. Served 1975-1976 as House vice-speaker.

☐ **Duane W Taebel, MD**
Vice-speaker of the House of Delegates

Graduate of University of Chicago School of Medicine, 1960. Internship at University of Chicago Hospital, 1960-61. Internal medicine residency at University of Chicago Hospital, 1961-64 and was chief resident in medicine, 1963-64. Fellow in gastroenterology, 1964-66, and was instructor, Dept of Medicine, University of Chicago Hospital. Served in US Army Hospital, Fort Devens, Mass, 1966-68. Received Wisconsin license in 1966 when joined Gundersen Clinic-LaCrosse Lutheran Hospital. In 1968 elected to membership in LaCrosse County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Board certified in internal medicine, 1968, and recertified in 1974. Board certified in gastroenterology, 1972. Was member of American Society of Cytology and Alpha Omega Alpha Honor Medical Fraternity. Holds memberships in American Gastroenterology Association and American Society of Gastrointestinal Endosopy. Is Fellow, American College of Physicians. Has served as chief-of-staff, LaCrosse Lutheran Hospital. Was president of LaCrosse County Medical Society, 1976 and serves on its insurance and executive committees, 1973 to present. Has been delegate to State Medical Society since 1972. Was member of SMS ad hoc committee on redistricting. Serves on Board of Control of Wisconsin Professional Standards Review Organization (WisPRO), 1975 to present. Also is on the WisPRO West Central District Review Council. Active in alcohol-related programs: director, LaCrosse Lutheran Hospital Detoxification Center; various consulting positions regarding alcohol abuse problems including appearance on state educational TV program on drug abuse.

Members, Nominating Committee

Chesley P Erwin MD, Milwaukee (Secretary)
John D Riesch MD, Menomonee Falls
William A Nielsen MD, West Bend
Leo R Grinney MD, Racine
District One

James N Moore MD, Madison (Chairman)
James J Tydrich MD, Richland Center
District Two

Cornelius A Natoli MD, LaCrosse
District Three

James D Kramer MD, Wausau
District Four

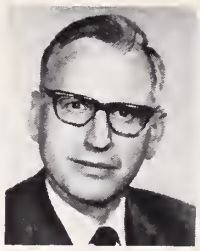
Timothy T Flaherty MD, Neenah
District Five

Wesley E McNeal MD, Green Bay
District Six

John A May MD, Baldwin
District Seven

Joseph M Jauquet MD, Ashland
District Eight

Joel E Taxman MD, Milwaukee
Specialty Sections


Dr Twelmeyer

Dr Derus

Dr Stuff

Dr Scott

☐ **Henry F Twelmeyer, MD**
Delegate to American Medical Association (1978-79)

Graduate of Marquette University School of Medicine, Milwaukee. Received internship at Milwaukee County General Hospital, 1942 to 1943. Served residency at Milwaukee County General Hospital, 1946-1949. Received license to practice medicine in 1943 and began practice of general and vascular surgery in Milwaukee in 1950. Has been alternate delegate to American Medical Association from State Medical Society of Wisconsin since 1971 and delegate to American Medical Association since 1976. Was president of Medical Society of Milwaukee County in 1971, served as member of that county's board of directors through 1974 and is currently its delegate to State Medical Society. Is a past president of Milwaukee Academy of Surgery and past member of Council of Wisconsin Surgical Society. Is fellow of American College of Surgeons, diplomate of American Board of Surgery, and member of Milwaukee Academy of Medicine. Is chief of staff at West Allis Memorial Hospital and has been chief of surgery at both West Allis Memorial and Elmbrook Memorial hospitals. Is associate clinical professor of surgery at Medical College of Wisconsin. Is past member of Board of Directors of Surgical Care-Blue Shield and past chairman of its Operating Committee. Is also member of Wisconsin Heart Association.

☐ **Gerald J Derus, MD**
Delegate to American Medical Association (1978-79)

Graduate of University of Wisconsin-Madison Medical School. Received internship at St. Mary's Hospital, Madison, 1952 to 1953. Received license to practice medicine in 1953 and shortly after starting in private practice founded the Monona Grove Clinic. Has been an alternate delegate to American Medical Association from State Medical Society of Wisconsin since 1974. Is Assistant Clinical Professor of Family Medicine at UW-Madison Medical School and has played active part in establishment of Family Practice Residency there. Is charter member of American Board of Family Practice. Served as President of State Medical Society, 1973-1974. Is former president of Dane County Chapter of Wisconsin Academy of Family Physicians, the Wisconsin Academy of Family Physicians, and Dane County Medical Society. Was chairman of Health Resources Committee of State Health Policy Council and member of board of Wisconsin Regional Medical Program. Serves on Standard Development Committee of Wisconsin Health Policy and Planning Division. Member of State Medical Society's Commission on Scientific Medicine from 1967 to 1972 and served as Commission chairman his final year. Recently appointed as a member of Committee on Evaluation of Delivery and Cost of Medical Care. Has been active in community and is chairman of board of Metropolitan National Bank which he helped organize.

☐ **Patricia J Stuff, MD**
Alternate Delegate to American Medical Association (1977-78)

Graduate of Woman's Medical College. Received internship at St Luke's Hospital, Chicago, Ill, 1955 to 1956. Served residency at Sacred Heart Hospital, Yankton, SD, 1956 to 1957. Received license to practice medicine in Wisconsin in 1957. Began general practice of medicine in Bonduel same year. Has been delegate to State Medical Society of Wisconsin from Shawano County Medical Society, 1966-1973. Became vice-speaker of House of Delegates in 1973. Also has served as member of State Medical Society's Nominating Committee and of House of Delegates reference committees. Member of board of directors of Wolf River Mental Health Clinic, founded by citizens' committee she organized in 1964. Headed clinic's board of directors in 1966. Served as vice-chairman of Unified Mental Health Board of Shawano and Waupaca counties and chairman of its planning committee 1974-1975. Is chairman of credentials committee of Shawano Community Hospital. Was recipient of "Woman of the Year" award by Shawano County Business and Professional Women's Association in 1971 and is listed in *Who's Who of American Women*. Serves as Adjunct Professor, University of Wisconsin-Oshkosh, 1975 to present.

☐ **John Kimball Scott, MD**
Alternate Delegate to American Medical Association (1978-79)

Graduate of Ohio State University College of Medicine, 1954. Interned at White Cross Hospital, Columbus, O, in 1954-1955 and residency at University Hospital, Columbus, O, 1955-1958. Received master's degree in physiology in 1950. Received license to practice medicine in Wisconsin in 1958. Has been in practice of otolaryngology in Madison since 1958. Was certified by American Board of Otolaryngology in 1959. Is associate clinical professor of otolaryngology at University of Wisconsin. Is on active staffs of St Mary's, Madison General, and University Hospitals, all in Madison. Is preceptor for fourth year residency program at Madison General Hospital. Past president of Dane County Medical Society 1975. Has been a delegate from Dane County Medical Society to the State Medical Society of Wisconsin for last seven years. Presently alternate delegate to AMA, 1976-1977. Served on State Medical Society reference committees, 1971 through 1973 and was a reference committee chairman in 1972 and 1973. Has been member of State Medical Society's Committee on Cancer since 1967 and its chairman since 1971. Member of SMS Committee on Medicine and Religion. Is secretary-treasurer of WISPAC. Has been national delegate to American Cancer Society since 1969 and is past president of its Wisconsin Division. Past president of State Society of Otolaryngology. Is member of Council, Wisconsin Chapter of American College of Surgeons. Member of American Academy of Ophthalmology and Otolaryngology since 1960 and American College of Surgeons since 1962. Is chairman of state commission on cancer, American College of Surgeons, working with Ancillary Committee of American Cancer Society and Wisconsin Clinical Cancer Center. Member of Society of Head and Neck Surgeons since 1963. Member of American Laryngological, Rhinological and Otological Society since 1972. Chairman of Board, WisPRO. Ruling elder of Christ Presbyterian Church, Madison. Member of board of directors of Winged Foot Club, University of Wisconsin Athletic Department. Team physician for sports at West High School, Madison. ■

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MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report
as of December 31, 1976

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

BARRON-WASHINGTON-BURNETT

Prentice, John W, Ashland to Route 1, Washburn 54891

DANE

Cooper, Garrett A, Madison, to 301 North Curculo, Dela Paladins, Green Valley, AZ 85614

Korbitz, Bernard C, Madison, to 8303 Dodge St, Omaha, NB 68114

FOND DU LAC

Sisk, James A, Fond du Lac, to 2155 Nelson, Dillon, MT 59725

LaCROSSE

Abbarah, Thabet, LaCrosse, to El Malab El Baladi, Homs Syria

MILWAUKEE

Krygier, Albin J, Milwaukee, to 306 Royal Dr, Horseshoe Bend, AR 72512

Seefeld, Philip H, Milwaukee, to 9608 N Linde Ct, Mequon 53092

DEATHS

Parkhurst, Howard J, Brown County, June 20, 1976

Christensen, H W, Marathon County, Nov 17, 1976

Grab, John A, Dane County, Nov 22, 1976

Ryan, Carlton J, Monroe County, Nov 30, 1976 ■

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OBITUARIES

◈County, State, AMA Members

◈ **Howard J Parkhurst, MD,** 82, formerly of Cleveland, Ohio, died June 20, 1976 in Green Bay. Born Nov 16, 1893 in Cleveland, Ohio. Doctor Parkhurst graduated from Western Reserve University in Ohio in 1918. Surviving is his widow, Elizabeth.

◈ **John A Grab, MD,** 81, Madison, died Nov 22, 1976. Born June 20, 1895 in Lena, Wis, Doctor Grab graduated from the University of Wisconsin Medical School in 1927. Doctor Grab had practiced in Milwaukee and Sun Prairie prior to his retirement. Surviving is a brother, Lawrence of Madison. ■

Alert to Members! DEADLINES FOR 1977 ANNUAL MEETING

February 14

Resolutions for the House of Delegates due in Secretary's office (two months before First Session)

If resolution involves expenditures, a "fiscal note" must accompany the resolution. SMS Staff will assist in preparation of fiscal notes.

Events

March

Publication in the *Wisconsin Medical Journal* of the Annual Meeting Program and summaries of the resolutions.

April 13

Council meeting

April 14-15-16

House of Delegates sessions

April 15-16

Scientific Program.

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▪ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

November 13, 1976 — Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Correll at 12:40 pm on Saturday, November 13, 1976, at the State Medical Society.

Voting members present: Doctors Williams, Boulanger, JJ Foley, Nielsen, Bruhn, Mullooly, Huth, Crowley, Tuftee, Waterhouse, Rohde, JJ Kief, Lewis, Peters, McKenzie, TF Foley, Smejkal, Doyle, Correll, Picard, and Stuff.

Others present (part or entire): Doctors Nordby, Watson, Froeschle, Lubitz, Kabler, Headlee, Grover, Strebe, Handy, Biek, Twelmeyer, Derus, HJ Kief, Collentine, Behnke, Scott, Levin; Dr and Mrs Schaeffer; Messrs Thayer, Johnson, Fetherston, Brower, Simms, Jensen, Brozek, Nelson, Bier, LaBissoniere, Wendle, Schweers, Lockerbie, McIntyre, Brown; Miss Pyre.

2. Approval of Minutes

On motion of Doctors Picard-Williams, carried, minutes of the September 11, 1976, meeting were approved.

3. Report of Executive Committee

The Council received minutes of the October 15 committee meeting, and an additional report on its November 12 meeting. The following matters were discussed or acted upon by the Council:

A. WPSIC Incorporation

The Insurance Department has indicated it would nc give attention to the Society's application for separate ir corporation of WPS until its report on the triennial aud of the plan was finalized. There are a number of area in which revisions in the preliminary report have bee requested by WPS. A communication relative to these ha just been received but not analyzed by WPS.

On motion of Doctors Huth-Mullooly, carried, the Counc approved the proposal that a meeting be arranged with M Wilde (Doctors Correll and Nordby, Messrs Thayer, Koeni and Murphy) to strongly urge the Commissioner to respon promptly to the application, and to inform him that if n satisfactory conclusion is reached by the end of the yea allowed following the effective date of the law, the Societ intends to use whatever legal means are necessary to secur a reasonable response from the Commissioner of Insurance

B. Patient Rights and Responsibilities

The Council discussed two statements, "Health Consumer' Bill of Rights and Responsibilities" developed by a DHS committee including health professionals and consumers, an a "Statement of Patient Rights and Responsibilities" pro posed by the Wisconsin Hospital Association. It was reporte that DHSS intends to circulate its statement as educationa guidelines, with compliance voluntary, and that the commit tee will meet again in about a year to assess and possibl revise the document. The WHA statement is recommende as an alternative.

After considerable discussion, on motion of Doctor Waterhouse-Stuff, carried, the Council took the position o not objecting to the distribution of either statement in a voluntary, nonpunitive, one year study program to evaluat the need and value of such statements. The Council furthe requested opportunity for input to the cover letter accom panying the DHSS statement, and understands there will b continued Society representation in the committee's year-en evaluation process, through the Commission on Public In formation.

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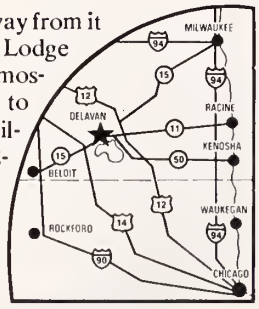

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C. Attorney General's Opinion re Chiropractic and Nursing Home Care

The Council reviewed the Attorney General's Opinion relative to ch. 119, Laws of 1975, which gives patients in nursing homes freedom of choice of health care providers under the Medicaid program. It was noted that the opinion raises questions of liability and conflict between state and federal laws. While clarification is being sought, the advice of Society legal counsel was requested for interim guidance of physicians.

On motion of Doctors Picard-Williams, carried, the Council requested that the content of the letter from legal counsel be disseminated to the membership.

D. Chiropractic Administrative Rule re "Ancillary Therapies"

The Council was advised of changes the Chiropractic Examining Board is seeking to make in the administrative code relating to the practice of chiropractic, including reference to "ancillary therapies" and "diagnostic and analytical instruments and procedures" which are not adequately defined.

On motion of Doctors Picard-Smejkal, carried, the Council urged continuation of efforts to seek elimination of these undefined terms.

E. Communications from Winnebago County Medical Society re WPS-HMP

(1) HMP requirements of formal referral of State employee HMP subscribers

The county society communicated to Doctor Correll its recent action withdrawing endorsement of HMP for State employees because of the formal referral requirement, concluding that "each participating physician may wish to determine whether to continue to participate in HMP or to withdraw from participation in HMP, particularly as it pertains to State employees."

The Executive Committee reported its understanding that WPS is continuing discussions with Winnebago County concerning the matter, but agreed with the letter's conclusion that individual physicians may continue to participate without the county society's endorsement of HMP.

(2) Supplement to State Group Master Contract

A second communication referred to provisions of the Supplement to the July 1, 1976, contract with the State Group Insurance Board, requesting "that the Council carefully and deliberately consider the provisions of the Supplement prior to their possible approval" and that "the SMS membership be fully informed, consulted and involved in the Council's decision-making process."

The Executive Committee reported its belief that the issue presented in this letter is the organizational structure of the Society. The Council, in requesting reports from WPS Commission prior to finalization of programs called for in the Supplement, is acting according to the Constitution and Bylaws, with authority of the House of Delegates between its sessions. The Council appreciates the concern of the county society and is most happy to hear its feelings.

The Council was informed that no new programs on which studies are called for in the Supplement will be implemented without approval by the State Medical Society.

On motion of Doctors Williams-Mullooly, carried, the Council requested that the county society be informed that these things are under study for possible change and that the Council will have an opportunity to establish policies at a later date.

The Exectuive Committee report was then interrupted for the following "special order."

4. Joint Practice of Physicians and Nurses

J D Kabler, MD, co-chairman of a joint practice committee with the Wisconsin Nurses Association, was present to discuss proposed "Guidelines for Implementation of Joint Practice of Physicians and Nurses" developed by the joint committee. He indicated his purpose was to have been a request for Council approval, but that since distribution of the guidelines to the Council, he was informed that the WNA Board of Directors had found them unacceptable. Doctor

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Kabler responded to questions from councilors, and several spoke favorably about the nurse practitioner program at UW-Oshkosh.

Doctors Rohde-Lewis moved that the Council commend the committee for its work and suggest that the guidelines continue to be revised as experience demands; and that the Council approve and make them available as tentative guidelines for those physicians interested in joint practice with a nurse practitioner.

On motion of Doctors Williams-Nielsen, carried, action on the motion was deferred until the January Council meeting.

Doctor Kabler said that the Joint Practice Committee would meet on November 19 and consider the question raised by the WNA Board, and hopefully would have a further report at the January meeting.

5. Executive Committee Report Continued

F. CT Scanners and Certificate of Need

(1) Medical Society of Milwaukee County Position

In responding to Doctor Correll concerning the county society's action urging physicians to utilize restraint in the purchase of CT scan equipment, its official position on certificate of need was transmitted. The Council did not object to the Executive Committee proposal that a recommendation be communicated to the county society on rewording a portion of its policy statement to more factually reflect federal law on certificate of need.

(2) DHPP Proposed CT Study

On motion of Doctors Picard-Mullooly, carried, the Council approved participation in a comprehensive study of CT scanners as proposed by DHPP on invitation to the Society secretary as well as representatives of Blue Cross, the Wisconsin Hospital Association, and the Medical Society of Milwaukee County.

G. Division of Health Proposed EPSDT Study

The Executive Committee, on the basis of information available, recommended that the Society decline participation in a comparative study of the quality of health screening and follow-up between private physician offices and EPSDT public clinics. Doctor Biek explained that the acting director of the Division had requested the study, and that he desired participation from the Society in establishing criteria if the study was considered feasible.

After discussion. a motion not to participate was defeated, and on motion of Doctors Waterhouse-Crowley, carried, the Council requested that the Executive Committee appoint appropriate physicians to work with Doctor Biek to determine the feasibility and criteria to be used in such a study.

H. Robert Wood Johnson Grant-Marathon County

Tabled, on motion of Doctors Smejkal-TFFoley, carried.

I. WHCRI/WisPRO

The Executive Committee proposed the following resolution:

WHEREAS, WHCRI was created at the initiative of the State Medical Society by action of the House of Delegates; and

WHEREAS, WisPRO was created by WHCRI and approved by the State Medical Society; and

WHEREAS, The Board of Directors and staff of WisPRO are to be complemented for their prudent and effective implementation of PSRO required review in delegated areas of the state; and

WHEREAS, The goals of both WisPRO and WHCRI relate to health care review, but their objectives are different—one in federally mandated programs and the other in non-federal programs—and much of the private sector does not wish to have its review subject to the policies of essentially government-controlled organizations; and

WHEREAS, WisPRO cannot operate in Southeastern Wisconsin whereas WHCRI has that capacity in non-PSRO activities, with cooperation of physicians and hospitals; therefore be it

Resolved, That the Council of the State Medical Society direct that WHCRI be continued as the parent organization, that WHCRI and WisPRO be maintained with dual boards to the extent allowed by law, a joint staff, and that WisPRO function to operate federally mandated programs in the area excluding Southeastern Wisconsin, and that WHCRI seek to act in the non-mandated areas of review for the entire state.

Doctors Picard-Waterhouse moved adoption of the resolution. After considerable discussion, on motion of Doctors Stuff-Mullooly, carried, the motion to adopt was tabled and the chairman was requested to appoint a committee to consider the matter of future WHCRI/WisPRO relationships and report at the next Council meeting.

Mr Thayer informed the Council that meantime, the private insurance industry is proposing to contract with WHCRI for review services and he anticipated that such a contract would be accepted sometime in December; also that WisPRO might conceivably seek to compete for such contract.

J. DHSS Citizens Advisory Committee on Psychotherapy Services under Medicaid

Doctor Correll summarized a minority report prepared by D A Treffert, MD, as a member of a special study committee on psychotherapy services in the Medical Assistance program.

On motion of Doctors Mullooly-Boulanger, carried, the Council approved the minority report and requested that the Society's support of it be communicated to the appropriate parties in state government.

K. Awards and Appointments

In executive session, the Council approved nominations of the Executive Committee for the Council Award, Presidential Citation, Distinguished Service Award, and Civic Leadership Award.

It also approved the recommendation of the Nominating Committee that Doctor Boulanger succeed Doctor Ovitt on the *Wisconsin Medical Journal* Editorial Board.

L. AMA Independent Direct Billing for Membership

The Council was asked for any advice it wished to offer the AMA delegation with reference to a proposal to be considered by the House of Delegates in December on direct billing for AMA membership. Doctor Twelmeyer as vice chairman of the delegation (Doctor Bell was attending the Interstate convention in Atlanta) suggested that Wisconsin might press for some advantage as one of the few "unified" states, to offset a loss of income from AMA of several thousand dollars if the latter billed and collected its dues, or there would be no reason except philosophical for Wisconsin to continue unified membership. Doctor Williams spoke in favor of sustaining unified membership and suggested the possibility of the AMA providing staff assistance to other states to continue billing and collection at the state level. No specific action was taken by the Council.

M. Charge for Emergency Room Use

A group of physicians who had equipped an emergency and cast room for use by physicians located in a medical office building inquired as to the refusal of insurance companies to honor charges for its use equivalent to those made by hospitals for emergency room use and supplies.

On motion of Doctors Picard-Mullooly, carried, the Council approved the Executive Committee's recommendation that such costs should be included in the professional fee; unless this office qualifies as nonprofit, the same rule applies as to a doctor's office—that such charge should be included in the professional fee.

6. Report of Committee on Economic Medicine

Doctor Rohde reported for information on the committee's review and in some instances approval of revised or new benefit offerings in insurance programs for members including WPS, Bankers Life, Provident Disability, and accidental death

and dismemberment. He also reported on Keogh program changes required to meet ERISA regulations, and that the Wisconsin Health Care Liability Insurance Program board will be considering a pro rata refund of premium for physicians terminating practice within a fiscal year.

7. Report of Finance Committee

A. Employees Pension Plan

On motion of Doctors Williams-Rohde, carried, the Council approved execution by Chairman Correll of a revised trust agreement incorporating changes previously authorized.

B. 1977 Operating Budget

All Council members received the proposed 1977 operating budget for the Society which is based on a continuation of dues at $300. Total anticipated income from dues and investments is projected at $1,225,000, and total budgeted expenses at a net of $1,109,885.

On motion of Doctors Mullooly-Williams, carried, the Council approved the budget as presented.

The Council was informed that the Medical Society of Milwaukee County has joined those county societies whose dues will be billed and collected by the State Society, and that arrangements will be made for cash advances early in the year as a line of credit against full dues collections.

C. Proposal for Establishment of Business Services for Members

Mr Thayer discussed the proposed development of services for purchase by members related to the business operation of their professional practice—management and business services of a variety of types, the first being a buying service for office disposables, supplies and equipment.

The Finance Committee recommended that an initial survey of interest be made of the membership and, if there proves to be sufficient interest, the retention of a consultant to undertake a detailed market research study followed by development of a corporate vehicle to operate such activity.

On motion of Doctors TFFoley-Mullooly, carried, the Council approved a preliminary survey on the joint buying service and allocation of up to $10,000 for a market survey and consultation to develop specific plans if there is sufficient member interest.

8. Report of Commission on Governmental Affairs

Doctor Lubitz reported that the Commission would support legislation providing for an advisory council to make recommendations to the Department of HSS on which genetic tests should be conducted rather than mandating certain tests by legislation; also an amendment of the statute requiring immunization for rubella at age 5 to provide for review at age 12 and immunization of the non-immunized at that time, rather than requiring premarital rubella testing.

He also commented on legislative proposals being considered by the Health Policy Council's legislative committee and indicated that the Commission supports proposals on health insurance for the uninsurable, minimum standards for health insurance, and support for Health Systems Agencies. The Commission also intends to study state health insurance proposals.

On motion of Doctor Huth, seconded and carried, the report was accepted.

9. Report of Physicians Alliance Commission

Mr Simms gave a status report on the Medical Defense Committee activities and indicated that at the January meeting there would be a report and recommendations on the basic positions to be taken in the Legislature on professional liability.

Mr Thayer and others reported on various developments related to Medicaid, including a proposed statement of the Society's views on overall management of Medicaid in response to the state's Medical Management Study Team request, the status of proposed provider agreements to be

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signed by physicians and other providers, the lawsuit on the fee freeze, and the fact that the state has invited the Society to begin negotiations on the freeze. This will be undertaken by the PAC Medicaid Committee with staff and legal counsel.

Councilor Kief urged that members be cautioned against signing Medicaid provider agreements should such be offered prior to completion of negotiations on revision of the initial draft.

10. Report of WPS Commission

Mr Lockerbie commented on the written report from the Commission including the September financial statement and a report to the State Group Insurance Board on concurrent inpatient review programs called for in the Supplement to the group master contract for state employees.

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11. Resolution on Health Planning

On motion of Doctors Lewis-Williams, carried, the Council adopted the following resolution:

WHEREAS, The American Medical Association has long supported health planning at the local level without total state direction, health planning that is flexible rather than rigid at all levels, and has encouraged physicians and their professional organizations to accept the responsibility of working in the planning programs at all stages in order to provide guidance in choosing goals and programs that will realistically meet community needs; and

WHEREAS, The State Medical Society of Wisconsin has been involved in statewide health planning since as early as 1916 and continuously since that date; as recently as 1971 officially expressed encouragement of voluntary approaches to health planning wherever possible but with recognition "that there is a need to provide local health planning agencies with some degree of authority so that they can assert a measure of influence over the adoption and implementation of their recommendations"; and

WHEREAS, The Society continues to recognize that the proper resolution of many of Wisconsin's health care problems requires health planning in a cooperative spirit involving physicians and other providers, government and the public; and

WHEREAS, It is clear from the collective experiences of physicians involved in the planning process since 1974 that the willingness of the profession to participate effectively in health planning is frequently thwarted by the unwillingness of the current system to permit it; therefore be it

Resolved, That the State Medical Society of Wisconsin support health planning on the basis of regional nonprofit public corporations which in Wisconsin have set a high standard for openness and public accountability; and be it further

Resolved, That the State Medical Society express its appreciation and support to all physicians who have voluntarily contributed their participation to health planning activities and urges them and their local professional societies to continue active participation wherever permitted in the health planning process, now primarily undertaken through the newly created Health Systems Agency program, in support of the Society's goal of achieving the highest quality health care at the most reasonable cost for all the citizens of the state.

12. Interprofessional Code Revision

Action was postponed pending opportunity for the Commission on Public and Professional Affairs to review additional amendments just received from the State Bar Board of Governors.

13. Miscellaneous

Doctor Rohde requested that at the next meeting there be discussion of a proposal (made at the Society's recent conference on HSAs) to provide a means for greater physician input to HSA boards and committee affairs. The proposal suggests a program such as is operated by the Minnesota State Medical Association.

14. Next Meeting — January 15, 1977

15. Adjournment — 5:20 pm.

Earl R Thayer
Secretary

Approved: January 15, 1977
HOWARD L CORRELL, MD
Chairman

Copy of the minority report of Doctor Treffert on psychotherapy services under Medicaid—item 5. J. of these minutes is attached to the original minutes and is available to members upon request. ■

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Do estrogens cause breast cancer in menopausal women?

THE PRESCRIBING of estrogens for healthy women is controversial because ovarian hormones have long been implicated in the development of breast cancer. In order to study the long-term effects of estrogen treatment of menopausal women, the medical histories of all women seen in one private practice in Louisville, Kentucky were reviewed. The incidence of breast cancer was followed for about 12 years in 1,891 Caucasian women who had been given conjugated estrogens for menopausal symptoms.[1] There were 49 cases of breast cancer observed; this was 30% greater than expected. The relative risk increased with longer follow-up. The relative risk was 0.9 in the first five years after starting of estrogen treatment, 1.2 from five to nine years, 1.3 between 10 to 14 years, and 2.0 for over 15 years.

The increased risk after 10 years was not simply the result of prolonged estrogen use, since there was no clear dose-response relationship to accumulated years of use.

The risk of breast cancer for women in whom benign disease had been diagnosed before estrogen therapy was about twice that of the general population. The risk among women in whom benign disease had been diagnosed after they had started taking estrogens was seven times greater than that of the general population. These observations suggested that benign disease and breast cancer may be part of the same response to an estrogenic stimulus, at least in some women.

Women who took higher doses of estrogen, or who took the medication other than on a daily basis, also appeared to have a higher risk. After 10 years two factors related to low risk of breast cancer, multiparity and oophorectomy, were no longer related.

The results of this study clearly indicate that menopausal estrogen use doesn't protect against breast cancer. The data do not indicate exogenous estrogens as a cause of cancer, but do raise the possibility of such a risk—DOROTHY BUCHANAN DAVIDSON, PhD, Wisconsin Clinical Cancer Center

[1]Hoover, Robert; et al: Menopausal estrogens and breast cancer. *N Engl J Med* 295:401-405, 1976.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

Head and neck cancer regional conference

The Head and Neck Cancer Network is planning three regional conferences to be held this spring at the Howard Young Center in Woodruff on April 23, St. Vincent's Hospital in Green Bay on April 27, and Madison General Hospital in Madison on May 4, from 9 AM until 3:15 PM. The faculty for each will be different, but there will be lectures in the morning on the head and neck exam and screen for family practitioners and dentists and workshops in the afternoon on the head and neck exam and prosthodontistry. For further information contact Jim Sasser, American Cancer Society, 611 N Sherman Ave., Madison, Wis 53704; (608) 249-0487.

Cancer symposium

The Ninth Annual Southeastern Wisconsin Cancer Conference on "The Dilemma: Endometrial Cancer (Estrogens, Diagnosis and Therapy)" will be held Saturday, April 2, from 9 AM to 2 PM in the Pfister Hotel in Milwaukee. There will be four speakers and a panel discussion. The chairman is Dr Frank Berridge, 8430 West Capitol, Milwaukee, Wis; (414) 463-1220.

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Supplement to the list of Visiting Oncologists

The following doctors are available to county medical societies, hospital medical staff meetings, medical specialty societies, and other physician organizations to present programs on human cancer:

From the Marshfield Clinic, Marshfield

TARIT K BANERJEE, MD: New Agents in Cancer Chemotherapy.
LELAND C CRANDALL, MD: Adjunctive Chemotherapy and Immunotherapy for Cancer.
ROBERT H GREENLAW, MD: Biological Effects of Radiation; Integrated, Modality Therapy in Cancer Management.
JAMES L HOEHN, MD: Estrogen Receptor Assays in Breast Cancer; Cancer of the Breast—Surgical Options; Melanoma; Soft Tissue Sarcoma—Combined Therapy; Occult Cancer of the Breast and Specimen Radiography.
SIDNEY E JOHNSON, MD: Endoscopic Diagnostic Techniques in Diagnosis of Biliary and Pancreatic Cancers.
JAMES H NICKERSON, MD: Childhood Leukemia, A Brighter Outlook; Solid Tumors in Children; Oncology for Family Practice Residents.
JOSEPH L OUSLEY, MD: Cancer Workup; Cancer Chemotherapy; Management of Common Cancers.
JOHN B WYMAN, MD: Dietary Fiber and Possible Relationship to Cancer of the Colon and Breast; Dietary Fiber and Diseases of Modern Western Civilization—An Overview.

From the Gundersen Clinic Ltd, LaCrosse

ROBERT H CAPLAN, MD: Endocrinology.
GREGORY H MAHAIRAS, MD: Gynecologic Oncology.
PAUL L FELION, MD: Colposcopy.
JEROME H GUNDERSEN, MD: Colposcopy.
RUDOLPH M KEIMOWITZ, MD: Hematology.

Lawrence J Logan, MD: Hematology.
Martin J Smith, MD: Hematology.
John B Weeth, MD: Medical Oncology.
William F Bingham, MD: Neurosurgery.
Francis S Tautin, DDS: Oral and Maxillofacial Prosthetics.
John E Clemons, MD: Otolaryngology and Maxillofacial and Plastic Surgery.
Charles N Ford, MD: Otolaryngology and Maxillofacial and Plastic Surgery.
Glenn M Seager, MD: Otolaryngology and Maxillofacial and Plastic Surgery.
Larry Severeid, MD: Otolaryngology and Maxillofacial and Plastic Surgery.
Larry A Lindesmith, MD: Pulmonary Disease.
Robert W Edland, MD: Radiation Oncology.
Richard S Howard, MD: Urology.
Fred A Schaldach, MD: General Surgery.

Requests for scientific programs may be directed to: Paul C Tracy, MD, Director, Regional Program, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705, (608) 263-3455; or David C Reynolds, Coordinator, Professional Education, address as above; (608) 263-6947. ■

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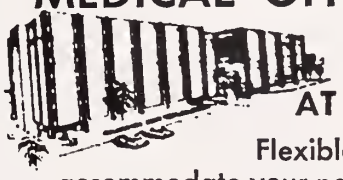

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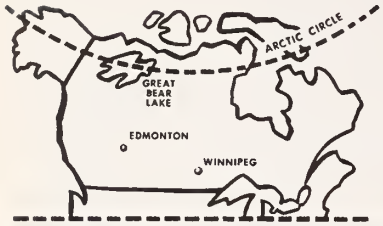

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Please note the Arctic Circle Lodge welcomes all guests for the remaining weeks of the 1977 season at the normal price of $1,225 from Edmonton, Alberta.

NEWS HIGHLIGHTS

Bellin Memorial Hospital

. . . this spring will begin a new concept of care for the terminally ill person. The Green Bay physician involved, Thomas R Leicht, MD,* says the program will be one of the first in the nation to offer a special team approach of both hospital care and home care for those who are dying. Doctor Leicht, an internist at Beaumont Clinic, in December gave up his practice to become medical director of the Bellin Hospice, as the program will be called. (A hospice is a way station for travelers. It is being used in this sense as a place to rest and conclude the journey of life.) The hospice will mean a team effort by family, pastor, and staff. The Wisconsin Conference of the Methodist Church has granted $6,000 initial funding. Planners hope to obtain another $50,000 grant.

American College of Chest

. . . Physicians recently inducted five Wisconsin physicians and surgeons as new Fellows of the College. They are: James F Hoffman Jr, MD* and Kiesl K Kaufman, MD,* Milwaukee; Marion K Ledbetter, MD* Madison; Carroll M Martin, MD, Racine; and Edward R Winga, MD,* LaCrosse.

Radiology Center

. . . at Sacred Heart Hospital, Eau Claire, was dedicated in December. The new center includes the highly sophisticated and expensive CT scanner.

The new center and its scanner, costing about $700,000, was installed through an agreement between Eau Claire's major hospitals and the generous gift provided by L E Phillips Charities, after whom the center has been named.

Luther Hospital officials agreed with a request of donors that no second scanner be installed in Eau Claire until there is full utilization of the one just completed.

At the donor's request, none of the capital costs of the project will be included in the bills of patients examined by the scanner.

The radiology center will provide access to the CT scanner for all qualified physicians in the area where the use is indicated.

Two CT Scanner Sites

. . . stir controversy in Green Bay. St Vincent Hospital and Radiology Chartered, the latter a private group, are both planning installations of CT scanners. State health planners are involved and the dilemma doesn't appear to be near solution. Efforts for compromise are underway but sources close to the situation believe only experience will decide whether two CT scanners in the same community are warranted and financially practical.

Ethical and Social Issues

. . . in Medicine is a new course being offered at the University of Wisconsin Medical School in Madison. It is designed "to introduce medical students to some of the forces other than microbes and tumors that affect patients," according to course director Norman C Fost, MD.

Instructors include physicians, medical historians, a philosopher, lawyer, and sociologist. They discuss issues including health insurance, government involvement in health care, euthanasia, and care of the dying.

Doctor Fost heads the UW's Program in Medical Ethics, one of only a handful of such programs in the country.

The Monroe Clinic

. . . in late 1976 established a satellite medical facility in Brodhead where the community has been without a physician for some time. A committee headed by Frank Stiles, MD,* Monroe, made a two-year study of the Monroe Clinic's responsibility to provide service to adjacent communities without adequate medical care. The former Stuessy Clinic building was purchased and is open two full days a week. A pediatrician and an internist each spend one day a week there. In addition a surgeon spends an afternoon once or twice a month at the new branch. A physician's assistant, registered nurse, and medical assistant are employed at the medical facility.

Physicians' Assistants

. . . The first nationwide study to determine the continuing educational needs of physicians' assistants (PAs)

continued on page 34

PHYSICIAN BRIEFS

Charles W Young, MD*

. . . Platteville internist for the past eight years, has discontinued his medical practice and has accepted the position of consultant in medicine for the State of Wisconsin. Prior to setting up practice in Platteville, Doctor Young spent one year in Madison and 10 years at Carbondale Illinois Clinic.

Erika Voss, MD

. . . recently was recruited by the Lafayette County Community Health, Inc, and will serve as a staff member, establishing her office for medical practice in Blanchardville. A native of Milwaukee, Doctor Voss completed her medical training at Georgetown University, Washington, DC. She has been practicing medicine for a number of years in India, East Pakistan, and countries in Africa. In 1973, Doctor Voss returned to the United States and helped establish a health care center near Memphis, Tenn.

Kermit D Hoyme, MD

. . . urologist, recently joined the medical staff of the Quisling Clinic, Madison. A graduate from the University of Illinois Medical School, Doctor Hoyme spent two years in the United States Army and completed his residency at Henry Ford Hospital in Detroit.

Bernard J Haza, MD*

. . . Appleton, recently was elected president of the Wisconsin Society of Internal Medicine at the annual meeting held at Lake Geneva. Doctor Haza served as chief of the medical staff at St Elizabeth Hospital, Appleton, and is a preceptor at the University of Wisconsin Medical School, Madison.

William C Crawford, MD

. . . Berlin, recently became associated with L J Seward, MD.* Doctor Crawford is a graduate of the University of Maryland School of Medicine and completed his internship and residency at University Hospital of Jacksonville in Jacksonville, Fla. Prior to joining the Clinic, Doctor Crawford served as an emergency room physician at Putnam Community Hospital, Palatra, Fla.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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is underway at the University of Wisconsin-Madison.

Sigurd Sivertson, MD* and his staff from the UW Department of Continuing Medical Education will review the practices of 100 PAs randomly selected by the National Academy of Physicians' Assistants (NAPA). Conclusions drawn from the study will be used by PAs to improve their practices and by the Academy to determine whether a more extensive evaluation should be conducted.

Although Wisconsin requires certification of PAs, many states do not. Also, the exact duties of PAs and how much responsibility they should be given are somewhat uncertain in many areas of the nation. In Wisconsin, PAs' work must be conducted under the supervision of a physician, although the physician does not necessarily have to be present.

Doctor Sivertson says the project, sponsored by NAPA, will be completed within a year.

Physician's Assistant

. . . Program of the University of Wisconsin-Madison Center for Health Sciences, School of Allied Health Professions, will have its first graduating class in May, according to Sigurd E Sivertson, MD,* medical director of the Program.

The University will confer to the members of this first class a Bachelor of Science degree with a major as a Physician's Assistant (PA). Doctor Sivertson asks physicians wishing to employ these graduates to contact the Physician's Assistant Program, 610 Walnut Street, Madison, Wis 53706; (608) 263-5620.

In December 1973 the Wisconsin Legislature, working with an ad hoc committee of the State Medical Society, created the Physician's Assistant in Wisconsin. The University of Wisconsin-Madison was mandated to develop an education and training program for PAs.

Milwaukee Academy of Medicine

. . . recently held its 91st annual dinner meeting and the following officers were installed for year 1977. They are MDs Richard D Fritz,* president; Norman H Engbring, president-elect; Richard D Bourne,* vice-president; Chesley P Erwin,* secretary; Archebald R Pequet,* treasurer; and John P Mullooly,* librarian. ■

Daniel F Johnson, MD*

. . . Eau Claire, recently was elected chief of the medical staff at Luther Hospital. Other officers elected were MDs Peter H Ullrich,* vice-chief of staff; Richard P Linden,* secretary-treasurer; Daniel T Kincaid* and Robert M Lotz,* members at large of the executive committee. All physicians are from Eau Claire.

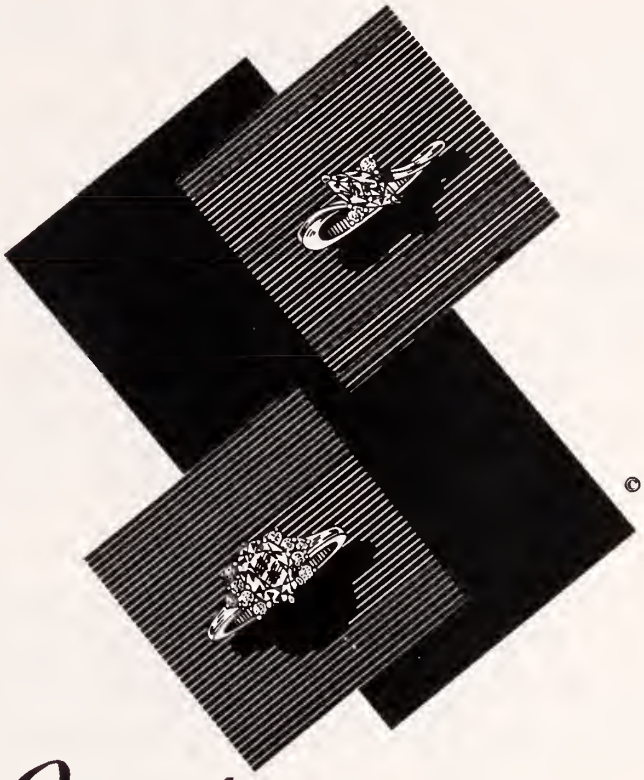
Richard G Edwards, MD*

. . . Kewaskum physician since 1932 recently retired from medical practice. A 1931 graduate of the University of Minnesota Medical School, Doctor Edwards started his general practice of Medicine in Kewaskum in 1932. He served as chief of the medical staff of St Joseph's Community Hospital, West Bend, and also as health officer for the Village of Kewaskum. In 1975 he received the Kewaskum Kiwanis Distinguished Service Award for his dedicated service to the community. In recognition for his services, the community started a Dr R G Edwards Health Care Scholarship Program for high school students who are pursuing a career in health care.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JANUARY 1977

3 Dane County HMP Committee
4 Dane County Medical Society Board of Trustees
5 Jail Health Care Project Committee
10 Madison Orthopedic Society
11 Medicaid Negotiations
12 SMS Committee on Federal Legislation
12 SMS Commission on Governmental Affairs
12 Executive and Legislative Committees, Section on Ophthalmology
13 Citizens Advisory Council on Alcoholism and Other Drug Abuse
13 SMS Committee on Medicine and Religion
14 Executive Committee of SMS Council
15 SMS Committee on Economic Medicine
15 Nominating Committee of SMS Council
15 Finance Committee of SMS Council
15 SMS Council
17 Dane County HMP Committee
19 WisPRO Executive Committee and Board of Control
20 SMS Committee on School Health
20 Madison Society of OB-GYN
21 Legislative Committee, Wisconsin Public Health Association
26 WisPRO Review and Evaluation Committee
27 SMS Commission on Public Information
27 Committee on Continuing Professional Education, Wisconsin Clinical Cancer Center
28 WisPRO Criteria Committee
28 Medical Defense Committee, Ad Hoc Committee on Professional Liability
28 Dane County HMP Committee
31 Dane County Physicians Alliance Committee

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parentheses.



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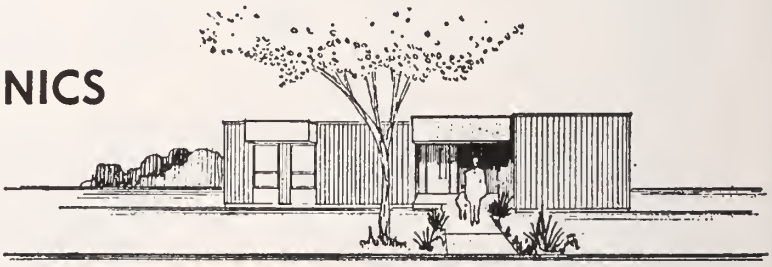
William A Lybrand, MD

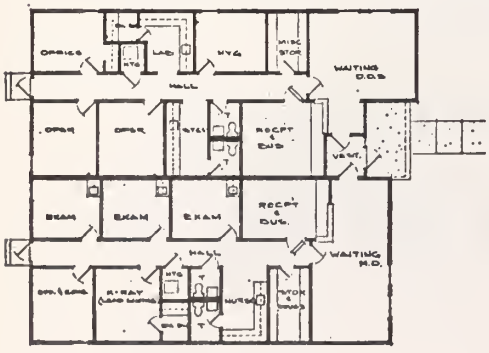
. . . vice-president of planning and program development of the Medical College of Wisconsin, Milwaukee, has resigned from the College effective May 1 to rejoin the federal government in a key health manpower assignment.

In accepting Doctor Lybrand's resignation, MCW president David Carley said, "Wil Lybrand's tenure here of a little in excess of one year has been an extremely helpful contribution to the program planning of the Medical College. His activities, particularly in the successful winning of the federal construction grant for the new medical education building and the passage of the Froedtert teaching hospital through the HSA were among his numerous accomplishments while here.

"His assignment in Washington will be an important one. The responsibility of the Bureau of Health Manpower in HEW to implement and administer the new health manpower bill is an assignment that everyone in health care in the United States is concerned about."

MEDICAL & DENTAL CLINICS





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Willard Sumner, MD*
. . . (left) is shown receiving a plaque from Victor S Falk, MD* (right) chief of the medical staff of Memorial Community Hospital, for his 50 years of service to the Edgerton community. Doctor Falk said, "He's delivered a great share of the local population." Doctor Sumner served as local health officer and also as president of the Edgerton School Board among other civic duties.

Mayuri Raval, MD
Pinakin Raval, MD
. . . have recently joined the medical staff of the Berlin Memorial Hospital. Dr Mayuri Raval, pathologist, completed her residency in Anatomical and Clinical Pathology at the University of Missouri, Kansas City, and at University of New York, Downstate Medical Center, Brooklyn VA Hospital. She is the director of laboratory at the Hospital. Dr Pinakin Raval, an internist, is associated with MDs David Sievers* and Alonzo Gimenez.* Prior to coming to Berlin, he was director of Medical Education at the Missouri State Chest Hospital and had been an assistant clinical professor at the University of Missouri, Columbia.

Clyde E Siefert, MD*
. . . Oconto Falls general practitioner, in December announced the employment of Mrs Sharon Strain as a physician's assistant. She received a degree in vocational nursing from Stockton Junior College, Stockton, Calif. She also attended the University of Wisconsin-Wood County Campus and UW-Stevens Point. She then attended Marshfield Medical Foundation's Physician's Assistants Program. She also has had special courses in coronary care at Wisconsin Rapids, first aid instructor's course at Marshfield, and an emergency medical technician course at Beatty, Nev.

Ted Ramos, MD*
. . . recently was elected president of the medical staff of Ripon Memorial Hospital. Other MDs elected to office were MDs Robert House,* vice-president and Jean House, secretary-treasurer. All physicians are from Ripon.

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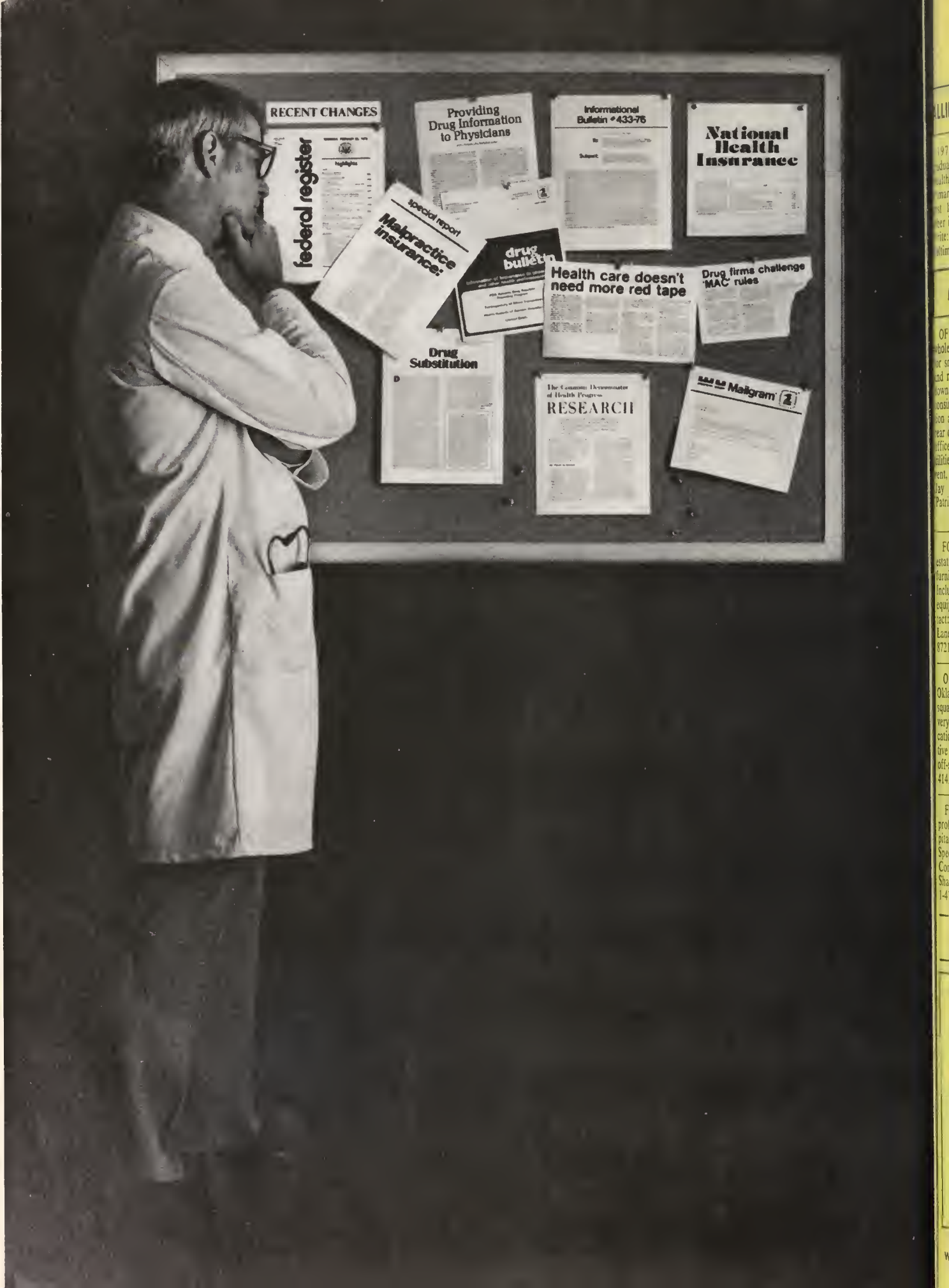
RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
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ALLIED HEALTH SERVICES

1977 PHYSICIAN ASSISTANT graduate of the Johns Hopkins School of Health Services seeks employment in a primary care setting. Available July-August 1977. Professional credentials and other information available upon request. Write: P Rea Katz, 2529 Guilford Ave, Baltimore, MD 21218. p2-3/77

MEDICAL FACILITIES

OFFICE SPACE AVAILABLE: whole floor 3400 sq ft or part of floor for smaller office is desired. Will divide and remodel to your choice. Located in downtown Milwaukee, 174 West Wisconsin Ave. Convenient to all transportation and expressways. Parking garage in rear of building. Suitable for professional offices. Medical or dental laboratory facilities could be developed. Reasonable rent, long term lease if desired. Contact: Jay N Bhore, MD, 414/765-0225 or Patrick Meade, 414/276-1920.
7-12/76, 1-6/77.

FOR SALE — BY DOCTOR'S estate, medical equipment, fixtures, and furniture. Including some lab equipment. Includes cabinets, examination room equipment, and medical fixtures. Contact: Dorothy Burpee at 502 Barberry Lane, Edgerton, Wis or call 608/884-8721. gtfn/76

OFFICE FOR RENT; 5232 W Oklahoma Ave, Milwaukee. Over 600 square feet. Three examination rooms, very large waiting room. Convenient location (bus stop at front door). Attractive low-rise building. Easy on-street and off-street parking. Available now. Tel: 414/476-4666. 12tfn/76

FOR LEASE: OFFICE SPACE IN professional buildings adjacent to hospital existing and to be constructed. Specialists and general practitioners. Contact G P Williams, DDS, 1711 Shawano Ave, Green Bay, WI 54303; 1-414/494-9541. 2tfn/77

PUBLICATIONS

Prescription Drugs and Health Care

A statement by Eli Lilly and Company on important health-care issues
Revised January, 1976

This 34-page, 8½x11, White Paper has been received in the WMJ office and is available on loan to anyone wishing a resource on health-care information, including the role that prescription drugs play in today's health-care delivery system.

CME Announcements

CONFERENCES FOR MEDICAL PROFESSIONALS.

Over 500 listings of national/international meetings, conferences and seminars in the medical sciences for 1977. Send a $10.00 check or money order payable to Professional Calendars, PO Box 40083, Washington, DC 20016. p1-6/77

PROFESSIONAL LEASE SPACE AVAILABLE

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OZAUKEE REHABILITATION CLINIC in Mequon. One block off the 141 Expressway, the 12,000 sq ft professional building also houses an Outpatient Rehabilitation Agency. Lease areas available on ground or upper levels. Will divide or finish to your specifications. Immediate occupancy.

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- Audiological Evaluations and Screening
- Industrial
- Hearing Conservation

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Mequon, Wis 53092

National Drug Abuse Conference May 5-9 in San Francisco: The theme of the 1977 National Drug Abuse Conference is "A Multicultural View of Drug Abuse." The conference, to be held May 5-9 at the Hyatt Regency Hotel in San Francisco, is chaired by David E Smith, MD; conference coordinator is Gail B Jara. Registration fee is $85. For more information, write to NDAC, 409 Clayton Street, San Francisco, Calif 94117; 415/626-6763.

AMERICAN MEDICAL ASSOCIATION
Continuing Medical Education AWARD

CATEGORY 4

Papers, Publications, Books and Exhibits

There is a limit of 40 credit hours for Category 4.

Ten credit hours may be claimed for a paper, publication or for each chapter of a medical or medically related book that is authored and published. A paper must be published in a recognized medical journal. The definition of a recognized medical journal is one that is published by an organization which requires a medical or medically-related degree for membership, or which has a readership that is made up of a majority of physicians or the allied health professions. A paper that is presented or an exhibit that is shown must be to a professional audience, such as allied health professionals and/or physicians. Credit may be claimed only once for the scientific information presented. Credit should be claimed as of the date materials were presented, published or the exhibit shown.

Medical editing cannot be accepted in any category of credit for the PRA.

* * *

The *Wisconsin Medical Journal* and the preparation/presentation of scientific exhibits at the Annual Meeting of the State Medical Society of Wisconsin are acceptable under this category. (The Annual Meeting Scientific Program of SMS is accredited for Category 1).

Summary of Events

Annual Meeting

State Medical Society of Wisconsin

Milwaukee Exposition and Convention Center and Arena (MECCA)

Marc Plaza Hotel (MP)

Thursday-Friday-Saturday
April 14-15-16 • Milwaukee

THURSDAY, APRIL 14

9:00 am—Breakfast and Meeting: Board of Directors, Wisconsin Academy of Family Physicians (MP)

10:30 am—SMS Scientific Section Delegates Caucus (MP)

2:00 pm—Milwaukee County Auxiliary and Aesculapian Society Convention Reception (Milwaukee County Historical Society Museum)

2:00 pm—First Session House of Delegates (MECCA)

7:30 pm—Open Hearing AMA Delegates (MP)

7:30 pm—Reference Committee Meetings (MP)

FRIDAY, APRIL 15

7:15 am—Medicine and Religion Breakfast: Catholic Physicians Guild (MP)

7:30 am—WISPAC Breakfast and Board Meeting (MECCA)

9:00 am—Scientific Program opens with Morning Plenary Sessions (MECCA)

12:15 pm—Socio-economic Luncheon (MECCA)

1:45 pm—Afternoon Plenary Sessions (MECCA)

4:00 pm—Second session House of Delegates (MECCA)

6:30 pm—Presidents Reception (MP)

7:30 pm—Presidents Dinner (MP)

SATURDAY, APRIL 16

8:00 am—Third Session House of Delegates (MECCA)

9:00 am—Morning Plenary Sessions (MECCA)

10:30 am—Council Meeting (MP)

12:15 pm—Scientific Luncheons followed by afternoon programs—specialty societies (MECCA)

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 9, 1976.

1977 WISCONSIN

Mar 11-17: Marquette-MCW Medical Alumni Association Clinical Conference, Island of St Maarten in the Caribbean. See details in box elsewhere in this section.

Mar 17: *Psychopharmacology Workshop*, Winnebago Mental Health Institute, Winnebago. See details in box elsewhere in this issue.

Mar 17-18: Trends in Radiologic Technology, presented by Dept of Radiology, University of Wisconsin Center for Health Sciences, with UW Dept of Continuing Medical Education, Health Sciences Unit, UW-Extension, at The Wisconsin Center, Madison. See details in box elsewhere in this issue.

Mar 23-30: Medical College of Wisconsin's 10th Annual Postgraduate Course in *Gynecological Pathology, Cytogenetics, and Endocrinology*, at the Pfister Hotel and Tower, Milwaukee. Info: Charlotte Templeton, Course Coordinator, Dept of Gyn-Ob, MCW, 8700 West Wisconsin Ave, Milwaukee, Wis 53726; ph 414/257-5580.

Mar 31-Apr 2: Ophthalmology Current Concepts Seminar, UW Dept of Ophthalmology Faculty and Davis & Duehr Eye Clinic Staff, Madison. See details in box elsewhere in this issue.

Apr 2: Ninth Annual Southeastern Wisconsin Cancer Conference, Pfister Hotel, Milwaukee, Wis. See details in box elsewhere in this issue.

Apr 19-20: Patient Education in the Primary Care Setting, presented by University of Wisconsin Center for Health Sciences and Dept of Family Medicine and Practice with Dept of Continuing Medical Education, Health Sciences

University of Wisconsin-Madison

Ophthalmology Current Concepts Seminar

Lectures and workshops in all subspecialty areas

Sponsored by Department of Ophthalmology Faculty, University Hospitals, Madison, Wisconsin; and Davis & Duehr Eye Clinic Staff, Madison, Wisconsin

March 31-April 2

Conference fee: $50

For further information contact:

Frederick Brightbill, MD
Dept of Ophthalmology
1300 University Avenue
Madison, Wisconsin 53706

608/262-3835

12th Annual Marquette-MCW Medical Alumni Association

CLINICAL CONFERENCE

Mullet Bay Beach Hotel
Island of St Maarten
in the Caribbean

March 11-17, 1977

Four-day scientific program, six full hours a day, qualifies under new IRS regulations for overseas conventions.

Full-time faculty from the Medical College. All physicians invited to attend (you don't have to be an alumnus).

Further info: Marquette-MCW Medical Alumni Association, 561 North 15th St, Milwaukee, Wis 53233; phone 414/257-8200.

Unit, UW-Extension, at The Concourse Hotel, Madison. See details in box elsewhere in this issue.

Apr 22-23: *Symposium on Critical Care Medicine*, sponsored by the Wisconsin Society of Critical Care Medicine, at Lutheran Hospital, Milwaukee. Info: Shirley Hagen, Executive Secretary, 700 North Water St, Milwaukee, Wis 53202.

Apr 29: *Alternatives to Drug Abuse and The Grief Process*, Winnebago Mental Health Institute, Winnebago. See details in box elsewhere in this issue.

Apr 30: One-day symposium on *Basic Sciences and the Clinical Practice of Anesthesia*, at Hoffman House-Midway Motor Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

May 12: *Staff Burnout Syndrome*, Winnebago Mental Health Institute, Winnebago. See details in box elsewhere in this issue.

May 25: *Child Psychiatry Workshop*, Winnebago Mental Health Institute, Winnebago. See details in box elsewhere in this issue.

May 25: One-day symposium on *Office Dermatology* 1977, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for

Ninth Annual Southeastern Wisconsin Cancer Conference
Pfister Hotel—Milwaukee Wisconsin

The Dilemma: Endometrial Cancer (Estrogens, Diagnosis and Therapy)

April 2, 1977

8:30-9:30 am Registration

9:30-10:00 am James W Reagan, MD, Professor of Pathology, Case Western Reserve University, Cleveland, Ohio

10:00-10:30 am Darryl E R Townsend, MD, Professor of Obstetrics and Gynecology, Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, Chicago, Ill

10:30-11:00 am Coffee

11:00-11:30 am Wm T Moss, MD, Professor of Radiology, University of Oregon School of Medicine, Portland, Ore

11:30-12:00 n Saul B Gusberg, MD, Professor and Chairman, Dept of Obstetrics and Gynecology, Mt Sinai School of Medicine of the City University, New York, NY

12:00-1:00 pm Luncheon

1:00-2:00 pm Panel Discussion Moderator: Dr David V Foley, Chairman, Dept of Obstetrics and Gynecology, St Joseph's Hospital, Milwaukee, Wis

Credit: 3 Hours of AMA Category I. Also 3 hours of elective credit by AAFP can be attained. Cosponsored by the Medical College of Wisconsin

Conference Chairman: Frank E Berridge, MD

TRENDS IN RADIOLOGIC TECHNOLOGY

Presented by Dept of Radiology, Center for Health Sciences, University of Wisconsin-Madison, and Continuing Medical Education, Health Sciences Unit, University of Wisconsin-Extension

MARCH 17-18/Madison
The Wisconsin Center

Objectives: To familiarize technicians with new equipment and procedures, to review and update routine work, to improve film quality and to reduce radiation to patients and employees, and to establish lines of communication between faculty and registrants.

Planning Committee: Francis F Ruzicka, MD, chairman, Dept of Radiology, and director, Continuing Education in Radiology; Mary Ellen Peters, MD, assistant clinical professor of radiology, and director, Diagnostic Radiology; and John R Cameron, PhD, professor of radiology and medical physics, Center for Health Sciences, University of Wisconsin-Madison.

Conference Chairperson: Janet A Marshall, RT, tech director of continuing education, Center for Health Sciences, UW-Madison

Fees: $30 for both days; $20 for one day.

Credit: UW-Extension, Dept of CME offers CEHs for this program. ECE points may be applied for from ASRT.

Faculty: University of Wisconsin Medical Physics Dept and physicians and technicians of Madison's VA Hospital, University Hospitals, and Madison General Hospital.

Further info: CME Coordinator, UW-Extension, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

PATIENT EDUCATION IN THE PRIMARY CARE SETTING

Two-day conference presented by University of Wisconsin Center for Health Sciences Dept of Family Medicine and Practice and Dept of Continuing Medical Education Health Sciences Unit, University of Wisconsin-Extension

Tues-Wed/April 19-20
Concourse Hotel/Madison

Objectives: To focus national attention on the role of patient education in primary care; to present an update on the current state of the art in primary care patient education, both nationally and locally; to provide a setting for a discussion of needs and problems in effective patient education; and to enable individuals involved in the broad spectrum of primary care patient education to share their ideas, programs, resources, and research.

Chairpersons: John H Renner, MD, chairman, and Dorothy M Blobner, MS, Dept of Family Medicine and Practice, University of Wisconsin Center for Health Sciences, Madison.

Faculty: Donald Bosshart, EdD, associate director, Office of Research in Medical Education, University of Texas-Galveston; Gary Gilmore, PhD, assistant professor, Community Health Education, University of Wisconsin-LaCrosse; Lawrence W Green, PhD, associate professor and head, Division of Health Education, School of Public Hygiene and Public Health, Johns Hopkins University; H Winter Griffith, MD, associate professor, Dept of Family Practice and Community Medicine, College of Medicine, University of Arizona-Tucson; Robert L Johnson, president, National Center for Health Education, San Francisco; Nada Leman, RN, BS, patient education coordinator, Carle Clinic Association, Urbana; and Irving Shapiro, PhD, educational consultant, adjunct associate professor, School of Public Health, Columbia University-New York.

Fee: $110.

Credit: Meets criteria for Category I credit for the PRA of AMA; WAFP prescribed credit applied for; CEHs available

Further info: CME Coordinator, UW-Extension, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

UNIVERSITY OF MINNESOTA

Continuing Medical Education Programs

Spring 1977

Practical Otolaryngology: Update 1977—February 21-22

Allergy and Clinical Immunology—March 17-19

Psychiatry (Advances in Communication Skills)—March 24-25

Thoracic Diseases—March 24-25

Current Topics in Clinical Laboratory Science—April 20-23

Topics in Geriatric Medicine—April 28-29

Glaucoma—May 2-3

Clinical Genetics—May 6-7

Practical Dermatology in Primary Care—May 12-14

Current Concepts of Heart Disease—May 20-21

Current Concepts in Radiation Therapy—May 25-27

Clinical Pharmacology and Therapeutics: A Pediatric Perspective—June 1-3

Clinical Hypnosis—June 3-4

Management of Colorectal Problems for the Family Physician—June 3-4

Vascular Surgery—June 13-15

National Pediatrics Conference—June 16-17

Management of Cerebral Palsy—June 13-18

For further information contact:

Ruth K McIntyre
Continuing Medical Education
Box 293
Mayo Memorial Building
University of Minnesota
Minneapolis, Minnesota 55455

Equal Educational Opportunity

AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

1977 AMA

Mar 30-Apr 1: 30th National Conference on Rural Health, Seattle, Wash, Washington Plaza.

Jun 18-22: AMA Annual Meeting, San Francisco, Calif, Fairmont Hotel and Tower; San Francisco Convention Center—Brooks Hall.

Aug 8-13: "Medinfo '77"—2nd International Conference on Medical Computing, cosponsored by the Canadian Medical Association, International Federation for Information Processing; and World Health Association.

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Dec 20-23: AMA National Leadership Conference.

Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

1977 OTHERS

Mar 2-5: Thirty-third Annual Midwest Clinical Conference, at McCormick Inn, 23rd and the Lake, Chicago, Ill. Sponsored by Chicago Medical Society with participating Chicago specialty societies. Info: Chicago Medical Society, 310 S Michigan Ave, Chicago, Ill 60604; ph 312/922-0417. 1-2/77

Mar 11-17: Twelfth Annual Marquette-MCW Medical Alumni Association Clinical Conference, Mullet Bay Beach Hotel, Island of St Maarten, in the Caribbean. Four-day scientific program, six full hours a day, qualifies under new IRS regulations for overseas conventions. Full-time faculty from Medical College. All physicians invited to attend (you don't have to be an alumnus). For further information contact: Marquette-MCW Medical Alumni Association, 561 N 15th St, Milwaukee, Wis 53233. Phone 414/257-8200. 1-2/77

Mendota Mental Health Institute—Madison Wisconsin

Division of Mental Hygiene Department of Health and Social Services

Reality Orientation: What It Is and Is Not

A seminar presented by the staff of the Institute's Geropsychiatric Center

Friday, February 25

Objectives: To define the physical impairments which occur during the aging process that contribute to confusion and disorientation. To define techniques that may be used during individual contacts to help orient confused elderly persons. To plan a basic reality orientation program for individual or group class, including the population that would benefit and the activity to be used. To develop short and long-term goals for each patient in the class. To develop a method of measuring progress for each patient in the class.

Enrollment limited to 70 participants. Registration fee of 50¢ is payable on arrival.

Registration to: Inservice and Community Training Unit, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wis 53704; or phone 608/244-2411, ext. 345.

Childbirth Education Association of Milwaukee

Wisconsin State Workshop

Friday-Saturday, March 4-5

Beginning and advanced teacher training including:

—Breathing and relaxation skills
—Anatomy of labor and delivery
—Medications
—Basic nutrition
—Group dynamics skills
—Recent technology
—Bonding and maternal attachment
—Psychology of pain
—Organizational development
—Establishing support groups

Guest speakers: Dr Richard Stevens, *Psychological Strategies for Pain Management in Prepared Childbirth* and *Environmental Hazards of Pregnancy*. Lois Olson, CNM, former practicing nurse-midwife, currently on staff of UW-Milwaukee School of Nursing, *Technology of Labor and Delivery*.

Friday film night.

Child care available.

Fees to be determined.

For registration materials contact Carol Van Ryzin, 5615 Westway, Greendale, Wis 53129; 414/421-4922.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle
New York City 10023

Schedule of Upcoming Programs

February 21—March 6

Anaerobic Infections, Part 1, with Robert Fekety, MD, Head Division of Infectious Diseases, Dept of Medicine, Univ of Michigan, Ann Arbor.

Anaerobic Infections, Part 2, with William J Ledger, MD, Prof of Ob-Gyn, Univ of Southern California, and Director of Maternal Fetal Medicine at Women's Hospital, Los Angeles.

Carcinoma of the Prostate, with Earl Wendel, MD, urologist, Passavant Hospital, Chicago.

March 7—March 20

*Genetics for the Generalist: *Autosomal Dominant and Recessive Disorders, *Chromosomal and X-linked Disorders, *Multifactorial Disorders,* with Pomeroy Sinnock, MD, geneticist, and Director, Thomas Roderick, MD, geneticist, Ms Clareann Bunker, genetic associate, William Bromley, MD, ophthalmologist, and Morris Lambdin, pediatrician; Genetic Counseling Center, Ellsworth, Maine.

March 21—April 3

Terminal Cancer: The Hospice Formula for Pain Control and *Terminal Cancer: The Family's View,* with Sylvia A Lack, MB, Medical Director of Hospice, New Haven.

The Rational Use of Antibiotics in Surgical Patients, with Richard H Parker, MD, Chief, Section of Infectious Diseases, Veterans Administration Hospital, Washington, DC.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories. NCME provides programs in most videotape and videocassette formats.

CONTRIBUTIONS—CES FOUNDATION
December 1976

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for December 1976.

Unrestricted

Robert B Murphy; Donald and Mary Gill; Elmore P Huth, MD, Anonymous; Bill Wendle; 6 SMS members — *Voluntary contributions*

Restricted

1 SMS member — *Student Loans*
1 SMS member — *Charitable — Disabled Physicians*
Merck & Co, Inc — *Speakers Service*
NMC Projects, Inc — *General Scholarship*
Quisling Clinic — *Medical Student Summer Externship Program*
Anonymous — *Other Than CESF Projects*

Memorials

State Medical Society — *Herman A Schulz, MD; Weber C Hermann, MD; Dennis F Pierce, MD*
Dr-Mrs WD James — *Howard Christenson, MD*
Dr-Mrs CJ Picard; Barbara and Howard Brower — *LO Simenstad, MD*
Dr-Mrs EJ Nordby — *Judge Carl Flom*
Dr-Mrs JS Huebner; Mr-Mrs Donald B Idzik — *TL Dixon*
Gen Larson; Elnora Johnson — *Arthur Lutz*
Dr-Mrs Robert Schmidt — *LD Schreiber; Jack Blakesley* ■

Winnebago Mental Health Institute, Winnebago, Wis
March-June 1977 CME Programs

Mar 17: "Psychopharmacology Workshop," guest speaker, Robert O Friedel, MD, assoc prof of Psychiatry and Pharmacology; Dir, Division of Psychopharmacology, Univ of Washington.

Registration:	8:45 - 9:30	
Part I	9:30 - 12:00	Antipsychotic & Antidepressent Agents
Part II	1:15 - 3:00	Antianxiety Medications
Part III	3:00 - 4:00	Panel Discussion

Acceptable for 6 credit hours in CME Programs

Apr 29: "Alternatives to Drug Abuse" and "The Grief Process," guest speaker, John Brantner, PhD, Univ of Minnesota, professor, Dept of Clinical Psychology.

Part I	10:30 - 12:00	Alternative to Drug Abuse
Part II	1:15 - 3:00	The Grief Process

Acceptable for 4 credit hours in CME Programs

May 12: "Staff Burnout Syndrome," guest speaker Christina Maslach, PhD, prof, Dept of Psychology, Univ of California, Berkeley.

Part I	10:30 - 12:00	Current Research and Findings on staff burnout syndrome
Part II	1:15 - 3:00	Preventative measures for one staff burnout syndrome

Acceptable for 4 credit hours in CME Programs

May 25: "Child Psychiatry Workshop," guest speaker, Domeena Renshaw, MD, assoc prof, Dept of Psychiatry, Loyola University

Registration:	9:45 - 10:30	
Part I	10:30 - 12:00	Psychiatric Emergencies with children and adolescents; Child Psychopharmacology
Part II	1:15 - 3:00	Suicide and Depression in Children
Part III	3:00 - 4:00	Panel Discussion

Acceptable for 6 credit hours in CME Programs

Info: Steve Kearney, Dir of Educational Services, Winnebago Mental Health Institute, Box H, Winnebago, Wis 54985. Phone 414/235-4910, ext 316.

NEWS YOU CAN USE

VITAL RECORDS CERTIFICATES TO REQUIRE BLACK INK ENTRIES

Black is better! That's the word from the office of the State Registrar, which officially records all certificates of birth, death, marriage, divorce, and fetal death. The office reports that it is experiencing an increasing number of poor quality entries on certificates, whenever ink other than black is used, or whenever a worn typewriter ribbon is used. Beginning May 1 the State Registrar's office will not process or accept records which use ink other than black or a poor quality typewriter ribbon. See Raymond Nashold's letter in the LETTERS section of this issue.

MEDICAL ASSISTANTS SURVEY

Physicians may be asked to participate in a task analysis survey which will help determine the skills needed for a person to function effectively as a medical assistant. The survey, endorsed by the SMS Council, will be undertaken by the Lakeshore Technical Institute in Cleveland, Wisconsin, which trains medical assistants. The information will aid the Institute in curriculum emphasis in its accredited course of studies. The survey will contact more than 1,000 physicians and 1,000 medical assistants.

APPROVAL FOR AN INTERPROFESSIONAL CODE

The SMS Council, at its January 15 meeting, approved a new Interprofessional Code, establishing a series of "ground rules" between physicians and attorneys which will help develop harmonious working relationships between the two professions in litigation involving a patient. (This replaces the Interprofessional Code published in 1955.) Anyone interested in a copy of the new Code may contact SMS offices in Madison.

NO NATIONAL HEALTH INSURANCE THIS YEAR

The new secretary of the US Department of Health, Education, and Welfare, Joseph Califano, told the Senate Finance Committee last month that no national health insurance proposal is planned by the Carter Administration this year. Califano says that jobs legislation and welfare reform will take priority. However, he said that NHI eventually will be "one of the centerpieces" of the Carter Administration.

THE GOVERNOR CALLS FOR CERTIFICATE-OF-NEED

In his State-of-the-State message January 18, Gov Patrick Lucey once again requested passage of a certificate-of-need bill. The Governor told lawmakers, ". . . I will propose legislation during this session, as I have in the last two, to place reasonable restrictions on the purchase and construction of new medical equipment and facilities. It will also seek to prevent the expensive duplication of services which requires that patients and taxpayers not only pay for the care they receive, but the empty bed next to them as well. We cannot go on wasting money on unneeded facilities, unnecessary medical testing, and unwarranted surgery when that money could mean the difference between life and death for people who do not now have access to the basic minimum care they need." The Governor also called for "insurance for all who need it," perhaps by allowing certain people the option of obtaining "adequate insurance at a reasonable cost in the private market under a state regulated program or pool." Governor Lucy also called for legislation which would insure that "those who are able to purchase health insurance would be assured that coverage is comprehensive enough to provide them with the basic health care they need." ■

FLU VACCINE MORATORIUM LIFTED

The State Department of Health and Social Services on Friday, February 11, lifted the moratorium on the use of bivalent influenza A vaccine and Hong Kong B influenza vaccine. The moratorium on monovalent influenza A (New Jersey) vaccine remains in effect. The bivalent A vaccine was released to enable immunization against A Victoria influenza. The vaccine is being made available to private physicians and public health officers for use as in previous years. In order to qualify for liability protection afforded by the law for bivalent vaccine, private physicians, public health officials, and other providers must provide the vaccine for no charge and must have the patient sign the new voluntary consent form approved by the US Center for Disease Control. Influenza B vaccine will continue to be administered on a fee-for-service basis under the direction of a physician, and will be available through regular commercial channels.

NEW RULES ON CONTINUING MEDICAL EDUCATION

As of January 1, 1977 each physician in Wisconsin must accumulate a total of 45 hours of continuing medical education (CME) and submit proof of this prior to the annual re-registration for the calendar year 1980. Only courses and programs approved by the State Medical Examining Board will be accepted. The Board will accept those programs approved by the Council on Medical Education of the AMA or the American Osteopathic Association, or any AMA or AOA accredited group such as those involved with the Liaison Committee on Continuing Medical Education. Completion of programs accredited as Category I will fulfill the requirements of the law. As proof of compliance, the Board will accept (1) certification by either the providing institution or organization, or the AMA or the AOA; (2) a Physician's Recognition Award of the AMA or a certificate of continuing medical education from the American Academy of Family Physicians, awarded not more than 12 months prior to the beginning of the calendar year for which application or registration is being made; or (3) certification by a chief of service or head of department or director of medical education of the providing facility. Proof may be submitted at any time to the State Medical Examining Board office, and a record will be kept of the total hours submitted by each physician.

PROFESSIONAL LIABILITY LEGISLATION

A seven-bill package designed to improve the professional liability statutes in Wisconsin will be introduced into the Legislature this session. This package was developed through the SMS Ad Hoc Committee on Professional Liability. A story detailing the legislative package appears in the SMS ORGANIZATIONAL section of this issue.

SMS PROPOSES BETTER NURSING HOME REVIEW

The State Medical Society has proposed creation of a centralized mechanism to investigate alleged inadequate or improper treatment of nursing home patients. Society staff and physician members have met with Lt Governor Martin Schreiber and proposed the plan. The Society pointed out to Schreiber that any investigation of nursing home care is difficult since it involves so many parties: the nursing home administrator, medical director, one or more practicing physicians, nursing personnel, therapists, and one or more public agencies. SMS Secretary Earl Thayer told Schreiber, "The situation cries out for a centralized review program which can bring all the elements of review together, reach conclusions, and pinpoint responsibility of action." ■

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What Measure of Men are We?

THE RECENT Physician's Opinion Survey Report has been sent to all physicians. This report is based on a 50% return, which for things of this sort is an unusually high rate of returned questionnaires. It will be worth your while to reread the summary of findings, sent out by the SMS, for two reasons.

The first is that it can be helpful to know just what our fellow physicians are thinking; a large sampling like this is more accurate than a personal sampling in a hospital lounge. While we do all speak for ourselves, even in so speaking we are well advised to know what numbers of other physicians are sharing our views, or what numbers disagree (that is, are "wrong"). The second good reason to review once again the excellent summary of this physician's opinion survey is that it gives a remarkably accurate picture of what physicians today are all about.

Without pretending to be an expert, I can nonetheless practice my own art of interpretation. For example if we look at the survey results, we will find that physicians, at least the 50% who returned this survey made in Wisconsin, are willing to spend their SMS dues for political, legislative negotiation, and public relations efforts (total of 79%), with only 17% emphasizing educational or scientific efforts. Now if the survey is correct, and I see no reason to doubt it, then Wisconsin physicians overwhelmingly see their SMS as a negotiating vehicle within a complex society. This is substantiated by the fact that we are, on the whole, willing to pay much higher dues to support the newly formed Physicians Alliance Division, dedicated to just that purpose. Unfortunately this very fact may be a contributory factor in the slippage of the physician's image in the eye of the beholders, the public, and the body politic. Obviously it would be foolhardy to pretend such dangers as overcontrol, confusion of issues, and the like do not exist; but without making a judgment as to whether such a shift is good, or bad, wise or inevitable, we can see that it has occurred. We should then be able to defend the position, not in some desperate last ditch stand manner, but from a constructive point of view. To do this we have to see medicine as striving to meet the problems raised by public and politicians in a positive manner. Of course we do some of this; *eg,* the AMA health insurance plan, but even this comes across to the public as an echo rather than a primary contender for the public mind.

How did we lose this initiative? Of course I do not know the answer but I'd like to encourage the SMS membership to ponder the question mightily, hopefully to come to some different stance. One start can be to read the report, and apply our own powers of interpretation to the problem of just who we are. Many of the items show sizeable minorities on many questions asked; does not that affect our image?—RH

What Price Professionalism?

YOUR ATTENTION is called to two significant issues which, if not handled well, can hasten the slide from medicine as a profession toward a nonprofessional sort of trade.

The first is the Federal Trade Commission's most curious attempt to "prove" that physicians, through their organizations (AMA,SMS) are attempting to fix the price of their services. If this is done by any industry, to the detriment of the public; *eg,* higher prices than necessary, then it has been defined as a federal offense. As to the issue, I have been in practice thirty years and I've yet to have any mention made of what my fees should be, let alone the "heavy hand" of organized medicine (AMA,SMS) conspiring to raise my prices.

So far my charges have matched the general community scales, of course; too much over or too much under such an estimate would be difficult, or unrealistic. But the charges have been made that like a group of tradesmen we have met, behind closed doors and likely in cigar smoke filled rooms, to determine how much we can milk the public; this is the assumption carried in the charges, and strips us of our professionalism by that very assumption.

The second point is the curious struggle going on over advertising of services, prices, and specializations. This closely guarded aspect of professionalism seems to be in for hard times. This time the action comes through the Justice Department, and the issue is both advertising of fees and advertising the quality of services; are we "guilty" because we are in restraint of trade by so preventing public advertising? If even

a small portion of our AMA dues and SMS dues goes into fighting these two processes, each of which is designed to presume we have no professional standards, then it would be money well spent.—RH

Think Thalidamide

TWENTY-FIVE YEARS ago state medical journals were faced with an unusual problem. They were surfeited with advertising material and actually received complaints because of its great bulk. Ten years later, with the advent of the Kefauver legislation, the situation was completely reversed. Since that time many state journals have languished because of decreased advertising. During the past fifteen years, the number of new pharmaceuticals in the United States has been minimal and has been far exceeded by the number of medical products removed from the market.

The pharmaceutical companies continue to research new products, but the FDA requires literally tons and vanloads of confirmatory paperwork. Naturally, it takes a considerable period to review this material because of its sheer bulk. It has been suggested that a heavily bonded, unbiased professional group review and distill the material for proposed new medical products in order to expedite the work of the FDA. Such bonded investigators would be faced with stiff penalties for inaccuracies. However, this does not appeal to the FDA, and their usual stultified reply invariably is "but think of thalidamide."

Meanwhile new products are appearing in the European market where they have been developed. The modern use of beta blockers (in hypertension and the prevention of heart attacks and sudden death) has been pioneered abroad with the United States about 10 years behind. The potential saving in the US is at least 10,000 lives per year. The use of these drugs for heart attacks is at least five years away in the United States. Eventually some of these do reach the United States but in the meantime a number of ethical, innovative preparations are withheld from patients here.—VSF

Guillain-Barre Syndrome

The last time a paper on the Guillain-Barré syndrome appeared in the *Wisconsin Medical Journal* was October 1966 when the late Doctor Max Fox presented 11 cases. His paper covered a 25-year experience at the Isolation Hospital in Milwaukee. There was one fatality in his series. Doctor Fox concluded that the syndrome was a primary viral infection with subsequent development of an autoimmune reaction to nervous tissue.

There was renewed interest in the Guillain-Barré syndrome when 685 cases in the United States were reported since October 1, 1976, the day the national immunization campaign for swine flu began. Of these,

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354 people had received influenza vaccine (12 had received non-A/New Jersey vaccine) and 314 had not received the vaccine. (Seven patients received the vaccine after onset of the syndrome, and the status for 10 cases was unknown.) It is estimated that at least 50 million doses of swine vaccine were administered in the two and one-half months of the program. Twenty-eight deaths from Guillain-Barré were reported, including 14 recipients of swine flu vaccine, 13 with no vaccine and one with unknown vaccine status.

The National Institute of Neurological and Communicative Disorders and Stroke estimates the expected annual incidence of the syndrome to approximate one or two cases per 100,000, with about 90% of the cases recovering completely and a probable mortality rate of 5%. It is considered an autoimmune disease according to NINCDS.

Your attention is directed to the comprehensive article on Guillain-Barré syndrome in the current issue of the *Wisconsin Medical Journal*. This points out a multiplicity of etiological possibilities including toxicity from heavy metals, malignant disease, pregnancy, following surgical procedures, after many communicable diseases (not all necessarily viral) and after immunizations in general. It is interesting of the four patients in the paper, two had received swine flu vaccine and two had not.

There was a note in the medical section of *Time* magazine in 1948 reporting many cases of polio in Australian children following routine combined immunizations. Certainly these immunizations did not cause polio, but this suggests a temporary immunodeficiency that appears to be similar to that associated with the Guillain-Barré syndrome.—VSF ▪

SPECIAL TO THE JOURNAL

Generic Drug Law in Wisconsin

William J Maurer, MD, Marshfield, Wisconsin

HISTORICALLY, antisubstitution laws were passed by virtually all of the States of the Union in order to protect against counterfeiting and illegal substitution of one medication for another. The patent laws protect a company innovating a new drug for 17 years, and this has been an effort to protect the company that has put money into research and development of medications. These laws have resulted in an effort by the pharmaceutical industry to encourage physicians to develop habits in prescribing medications by brand name. Unfortunately, efforts are made by the pharmaceutical manufacturers to encourage physicians to continue to prescribe the drugs by brand name after the patent protection has expired. This is done by extensive advertising and detailing of the medication. This has resulted in artifically high prices of medications after the patents have expired and after competing companies have begun producing identical medications at a considerably lower cost.

In the past few years across the country, with the rise of consumerism and perhaps along with the emphasis in medical school training to prescribe drugs by their generic rather than brand name, there have come about efforts by diverse groups and by State Legislatures to partially repeal the antisubstitution laws. The rationale is that by passing laws allowing substitution of identical medications, the cost in some instances

Doctor Maurer is a member of the Wisconsin Drug Quality Council.
Reprint requests to: William J Maurer, MD, 1000 North Oak St, Marshfield, Wis 54449.
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can be reduced for quality prescription drugs. There is a group of drugs that may be therapeutically and chemically equivalent which are no longer protected by the patent laws. Cost savings might occur if physicians would prescribe these medications generically or if pharmacists would have some option to substitute truly equivalent drugs and if the patient or consumer would agree to the substitution.

A few years ago, the State Medical Society of Wisconsin invited representatives of the Departments of Pharmacology of the two state medical schools, representatives from the Retail Pharmacists Association of Wisconsin, and interested physicians, along with a physician representative of a pharmaceutical manufacturing corporation to discuss suggestions for legislation regarding drug prescribing and dispensing. At these meetings, it was felt that a complete repeal of the antisubstitution law and complete generic prescribing would not allow for quality and safe medications to be given to the public, as the only criterion might become the price. A completely generic prescribing law might also unduly penalize the ethical or brand name manufacturers.

Some of the suggestions coming from this meeting were as follows:

(1) A partial repeal of the antisubstitution laws might be feasible. That is, if a drug were prescribed generically it might be substituted with some attention to quality and cost.

(2) A brand name drug might be substituted only if the physician would not specifically signify "no substitution" on the prescription and the substitution would be to a lower cost medication.

(3) A Drug Quality Control Board consisting of pharmacologists, pharmacists, physicians, and consumer representatives in an advisory capacity could be formed under the auspices of the State Department of Health and Social Services and this Committee might review medications and develop a formulary.

(4) There must be attention paid in the law to the inventory problems of pharmacists so that they need not inventory the lowest cost drug on a proposed list and that they would have some judgmental leeway as to which medication would be substituted.

In 1976, the Legislature of the State of Wisconsin passed a partial repeal of the antisubstitution laws and did incorporate most of the above suggestions into the law. The law specifies that the physician be allowed to write "no substitution" if in his judgment the medication should not be substituted. If the physician did write the prescription by brand name and if the drug was in the Wisconsin Formulary, then a lower cost medication could be substituted. The pharmacist, however, would retain the right to fill the prescription as written by the brand name drug if he wished. The patient would be informed that a possibility for substitution was present and he or she would have the final decision as to whether substitution was to occur. If the prescription was written generically, the pharmacist would be required to fill the prescription with a medication that costs less than half of the average wholesale cost of all of the preparations of that particular drug in the Wisconsin Formulary.

The benefits and wisdom of the law are as follows:

(1) The law preserves the right of the physician to write "no substitution."

(2) The consumer is given a choice as to whether substitution should occur.

(3) A Drug Quality Council reviews and suggests medications that may be in a Wisconsin Formulary to make sure that the substituted medication is clinically and bio-equivalent.

(4) The pharmacist has increased discretion in that he is no longer required just to fill a prescription as written, but may make professional decisions which may be helpful to his customers in terms of quality and price.

(5) The pharmaceutical manufacturers continue to retain their patent rights for 17 years for new products to encourage their research and development.

(6) The manufacturer may still encourage a physician to dispense the drug by brand name and thus write "no substitution."

There is concern that by the process of substitution, the patient may not get a therapeutically or chemically equivalent and safe drug. The Drug Quality Council, therefore, operates under the following guidelines:

(1) The drugs considered for substitution must be drugs that are not single source drugs. That is, the patent rights must have expired so that multiple manufacturers produce the drug in order for it to be considered for the Formulary.

(2) The drug according to the law should be chemically equivalent and completely equivalent in dosage.

(3) The drug must be produced by a company having a NDA or ANDA with the Federal Food and Drug Administration for that drug and

must meet USP and/or NF standards. The manufacturer must submit to the Council the components of the drug product including inactive ingredients and must indicate the purity of active ingredients. The company must list the number of drug recalls; and if a drug on the Formulary is recalled, it is immediately removed from the Formulary. If appropriate and available, a summary of bio-availability and pharmacokinetic data in human subjects should be submitted. Dissolution rates should also be submitted. The Federal Food and Drug Administration is responsible in this country for the quality and purity of medications. However, it is the responsibility of the Wisconsin drug formulary committee (Drug Quality Council) to decide drug equivalence under the law. If drugs are judged to be clinically inequivalent, to have different bio-availability, or to have the potential for producing side-effects due to their inactive ingredients when substituted, these products are then deemed inequivalent and are not to be included in the Formulary. The Council may decide that a drug be included in the Formulary because it meets USP standards, it has a long history of safety, or that bioequivalence is not necessary because of wide ranges between the therapeutically effective dose and the toxic dose. The US Department of Health, Education, and Welfare has a publication that lists holders of NDAs for drugs presenting actual or potential bioequivalency problems and this data is also considered by the Drug Quality Control.

At a meeting of the Wisconsin Drug Quality Council in January 1977, a number of medications was considered and none of the medications was approved for inclusion in the Wisconsin Drug Formulary for various reasons. For example, the estrogen compounds were not included because of biologic differences and differences in their ingredients. Sustained action papavarine medications were not included because the FDA was currently studying this particular medication and because good absorption and bio-availability studies for sustained action papavarine were not available. Donnatal® and similar medications were not included in the Formulary because of slight differences in the doses of some of the secondary ingredients. Dilantin® (diphenylhydantoin) preparations were not included because of documented differences in therapeutic equivalence.

Perhaps a few comments would be in order regarding the various types of equivalence of drugs. Chemical equivalence is self-explanatory—that is, the drug should be chemically identical. Therapeutic equivalence implies that the drug would accomplish its intended purpose in an equivalent manner. It is apparent that therapeutic equivalence is the most difficult and expensive to prove. Indeed, the Federal Government has through the National Academy of Sciences suggested that therapeutic equivalence cannot and need not always be proved; that in some cases bioequivalence should suffice rather than therapeutic equivalence. Bioequivalence means that two different preparations of the same medication should give comparable blood or tissue levels within certain predetermined standards. It is true that different medications which are chemically equivalent and equal in dosage might not give identical blood levels. This might occur if there were differences in dissolution rates in vivo between the two preparations. In some cases the blood levels peak at different times and the drug is cleared from the system at different rates. There are, however, standards of variability regarding acceptable differences in bioequivalence and whenever possible these are reviewed by the Council.

There continues to be a problem, however, in the following concepts. The active ingredients of a medication may be chemically equivalent, but the medication may contain impurities. There may be differences in the binder or differences in disintegration and these may cause toxicity, allergic reactions, or differences in blood levels without differences in the primary therapeutic effect. It is well documented that medications which are chemically equivalent such as different brands of digoxin may not be bioequivalent or reach comparable levels in the blood due to dissolution problems. Occasionally, differences in chemistry may be present but may not not be therapeutically important. An example of this is ampicillin which is available in equal dosage forms as both an anhydrous and a trihydrate preparation. However, the bio-availability and the therapeutic efficacy of these two preparations may be equal. The problem remains as to whether they should be considered candidates for substitution.

The reactions of the various special interest groups in relation to the Generic Drug Law have been very interesting to observe. The pharmaceutical manufacturers continue to encourage physicians to prescribe by brand name and to write "no substitution." They suggest to the phy-

sician that the drug company research and development will be compromised if brand names are not used. They suggest that the manufacturers may not be able to recoup research and development costs, although usually not mentioning that the patent rights persist for 17 years. The pharmaceutical manufacturers may suggest that physicians or pharmacists may be liable if untoward effects occur from substituted drugs. Indeed, it is conceivable that physician might write ampicillin by brand name and that under the Wisconsin law the brand name prescribed might not have a compound as an inactive ingredient that would cause an allergic reaction. However, a substituted medication might contain this substance causing allergy. The question of liability in that case is not resolved. The large ethical manufacturers in some cases have gone into the generic medication production and seem to be able to provide quality medications with all of the distribution, research, and service back-up while still providing these medications at lower costs.

The pharmacists, while in many cases feeling that the law has good points and allows them more latitude in dispensing, have been concerned regarding the cost structure in the Wisconsin law. Many pharmacists feel that the published drug prices obtained by the State Department of Agriculture are not true or representative prices and indeed it is true that the drug manufacturers have used the tool of multiple drug pricings, rebates, and volume discounts extensively in their marketing. The retail pharmacists in some cases feel that it is unfair to the pharmacy profession as a group to be singled out in having to post for their customers the wholesale prices of their products. They point out that other groups are not required to post their prices. They feel that the differences between their actual prices and the listed prices will cause problems in complying with the law and in managing their pharmacies.

The Governor's Drug Quality Council has found that the Council is not the last word on the inclusion or method of inclusion of medications in the State Formulary, but is merely advisory to the State Department of Health and Social Services. For example, the Council pointed out that ampicillin trihydrate and ampicillin anhydrous, while perhaps therapeutically similar, are different chemically and should be listed separately. However, the State Department of Health and Social Services felt that this would be an unnecessary separation and would confuse the pricing structure; therefore, it has included these two separate chemical substances in one list.

The pharmacists on the Council have suggested that explaining the law to their customers as required may take too much time and have asked that a form be developed which would inform customers that substitution had taken place. This, they argued, would give the consumer a chance to respond if this is not what he wishes. Instead, the various legislative committees have designed a form for the new Formulary which requires additional paper work to be performed by the pharmacists and which requires the retention of this record for a two-year period. In addition, a consumer representative on the Council pointed out that this new form must be signed by the consumer and that such signing was not contemplated in the original law. It was further pointed out that having the consumer sign a form may make the consumer reluctant to allow substitution.

In spite of some of these problems, it appears that the partial repeal of the antisubstitution law (the Wisconsin generic Drug Law, Sec. 140.90 and 450.075, Wis. Stats. 1976) will help bring down prescription costs while maintaining the safety and quality of the medications dispensed to the consumer. It seems also that the pharmacists can live within the terms of the law and that the pharmaceutical manufacturers will respond by manufacturing drugs generically. This possibly will decrease the emphasis on extensive advertising by brand name and detailing. Their research and development costs will continue to be protected by the patent laws.

It is to be earnestly hoped that the administration of the law by the State Department of Health and Social Services will not change the original intent of the law through interpretation. The physicians right under the law to write "no substitution" if in their judgment substitution is not indicated must be preserved. The State Department of Health and Social Services should not hedge by interpreting therapeutic equivalence as chemical equivalence. The Drug Quality Council must continue to use strict standards in determining that the drugs for the Formulary meet the criteria of dose, chemical, and bioequivalence in cases where it is required when allowing drugs to be substituted.

Finally, the socioeconomic effects of this law must be documented to show that true cost savings do occur which justify the time and money spent developing and administering this law. ■

Physicians needed to serve on Patient Compensation Panels

Wisconsin physicians are needed to serve as members of the Patient Compensation Panels legislated in 1975.

All cases alleging medical malpractice committed in Wisconsin since July 24, 1975 must be heard by the Panels. According to Jeffrey Kravat, director of the Panels, physicians are somewhat reticent about serving on the Panels.

Physicians and the State Medical Society played a major role in developing the panel system through joint meetings in 1975 between SMS and the State Bar of Wisconsin.

The system was advocated by many physicians as a more desirable alternative to the tort system in the courtroom. Since physicians played a role in developing the system, Kravat hopes more physicians will participate in the actual implementation and operation of the system.

There are two types of panels: formal and informal. In matters which the claimant identifies as being under $10,000, the matter will be heard by an informal panel, unless all parties request a formal panel. Any matter involving more than $10,000 will be scheduled for a formal panel if any one party so requests.

Informal panels are composed of three people and formal panels of five people. Both panels decide by a majority vote whether the actions or omissions of the health-care provider were negligent; and if such actions or omissions were negligent, whether the negligence caused injury or death to the patient. If the panel determines that the claimant has suffered injury or damage, the panel may award compensation and benefits. The findings and order only of the formal panel are admissible in any subsequent court action.

Both panels are headed by an attorney-chairman. He serves an indefinite period for the formal panels. The formal panels have two lay people, two health-care providers, in addition to the chairman. The informal panels have a health-care provider and a lay person, in addition to the chairman. The informal panels are convened in the area where the incident allegedly occurred.

The state is divided into four areas for the formal panels: Madison, Milwaukee, Eau Claire, and Green Bay.

A physician is appointed to the formal panel for each district for a period of six months. The other health-care provider on the formal panel is appointed on a case-by-case basis. Physician members also are appointed on a case-by-case basis for the informal panels. The panel process takes about two days and schedules are built around the physician's schedule.

At least 34 cases have been heard by the Panels since the law went into effect. Of those cases, about one-third have been settled by panel decisions. To date two cases have been filed in court after going through the panel process.

The Physicians Alliance Division of the State Medical Society urges physicians to seriously consider participating on the Panels if requested by the director of the Panels. More information may be obtained by calling the SMS offices in Madison: 608/257-6781, extension 113. ■

Professional liability legislation to be introduced this session

The SMS Physicians Alliance Commission has approved a six-item legislative package designed to improve the professional liability laws in Wisconsin.

The bill drafts resulted from much deliberation by the SMS Ad Hoc Committee on Professional Liability, chaired by Dr Frederick Kriss of Madison.

One legislative draft, already approved by the Legislative Malpractice Committee, would reduce the statute of limitations for minors from age 19 to age 8, or the adult statute of three years, whichever is later in time.

The Legislative Malpractice Committee consists of physicians, other health providers, attorneys, legislators, and public representatives.

A State Medical Society legislative draft would require that expert medical witnesses in professional liability actions be (1) licensed and practicing in Wisconsin; and (2) qualified by experience, training, and knowledge to testify on the subject at issue.

Two bill drafts are being considered from Wisconsin legislators. These drafts provide for recovery of court costs and reasonable attorney fees, if a suit were determined to be frivolous; that is, without foundation or fact.

Another SMS legislative draft, this one dealing with the Collateral Source Rule, would prevent duplicate payments for the same item of liability.

To allow for a simultaneous countersuit, an SMS draft would allow a counterclaim for damages to be filed and litigated concurrent with the original action, if that original action is thought to be without legal or factual basis.

A final SMS legislative draft would provide an alternative to the tort system for resolving medical liability claims. The draft makes use of the formal panel system, currently operating, but with results of the arbitration process being binding on both parties. The draft also clears up confusion in the statutes on whether arbitration is a viable alternative to the courtroom. ■

SMS Annual Meeting Program appears in this issue starting on page 23. ■

SMS Variable Annuity Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.39085410 as of January 31, 1977. ■

SMS Bylaws read, in part: Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary of this Society on or before March 31 shall be deemed delinquent until his name is properly reported and his dues for the current year properly remitted. ■

Resolutions set issues for year

The House of Delegates will consider resolutions ranging in subject matter from unified membership to the depilatron method of hair removal at the State Medical Society's Annual Meeting in Milwaukee April 14-16.

The following resolutions were received in the Secretary's office by the February 14 deadline. These will go to the House of Delegates for action during its three sessions at the MECCA. Members are urged to express their opinions to their delegates and to participate at the Annual Meeting Reference Committee hearings where resolutions are discussed.

Complete details of the Annual Meeting Program as well as a list of the delegates and alternates appear elsewhere in this issue.

(The county medical society, physician or specialty section which introduced the resolution appears in parentheses.)

1. (Dane) Unified Membership

Asks that "the State Medical Society eliminate its constitutional unified membership requirement, that membership in the AMA be established as optional, and that dues for county and state medical societies be billed separately from those of the AMA."

2. (Fond du Lac) Unified Membership

Asks that the policy of unified membership be abolished.

3. (Waukesha) Unified Membership

Instructs the Council to carry out a mail referendum of all SMS members "to determine whether or not each member favors, or not, the requirement of mandatory AMA membership in order to be a member" of SMS. A majority vote would be binding upon the Council. Referendum would be held prior to October 1977.

4. (DeLore Williams, MD) Unified Membership

Calls upon each Wisconsin physician for "a renewed interest and support of organized medicine as a continuum of county, state and national effort, rejecting any effort to end the 'Unified Membership' concept and policy in Wisconsin."

5. (House of Delegates Nominating Committee) Multiple Office Holding

Establishes a new policy for the State Medical Society of Wisconsin "that no member shall serve concurrently as a constitutional officer of the Society and as a delegate or alternate delegate to the American Medical Association."

6. (Fond du Lac) Nominations for SMS President

Directs the Nominating Committee to "submit the names of at least two individuals for the nomination of President of the State Society; and that these individuals, plus any floor nominees, be allowed to present a brief talk before the House of Delegates prior to the election of the President of the State Medical Society of Wisconsin."

7. (LaCrosse) Reporting by AMA Delegates and Alternates

Directs the Council to study and offer a plan "for the AMA delegates to report to their constituents at some type of personal appearance at meetings throughout the state the actions of the AMA House of Delegates. These meetings would also afford a mechanism for the individual members to communicate their thoughts and desires on legislative action to the delegates."

8. (Wood) Wisconsin Physicians Service

Directs the House of Delegates to restate "its request to the elected officers of the State Medical Society to sever all *financial* and *personal* connections with Wisconsin Physicians Service as soon as possible and to fully report to the membership on the present state of negotiations to that end."

9. (Lincoln) Blue Plans

"RESOLVED, that (1) any contractual relationships, where they exist, be considered void; (2) the State Medical Society of Wisconsin negotiate with the Blue Plans to cease the practice of arbitrarily and unilaterally setting physicians' fees; (3) the Blue Plans be enjoined from misrepresenting their policies as providing full coverage for usual and reasonable fees when in effect they are not; (4) the Blue Plans, if they do continue the practice of discounting fees under a profiling system, permit full disclosure and make these profiles available on a statewide basis by physician classification or code; and (5) the Blue Plans discontinue the practice of advising patients, expressly or implicitly, that physicians' billing for the discounted balance is unethical or illegal without prior contract."

10. (Winnebago) Psychiatric Medical Services Insurance

"RESOLVED, that it be the policy of the State Medical Society of Wisconsin that health insurance policies

Unless funds found, Museum-Hall of Health to remain closed

Unless a new source of revenue is found, the Old Fort Crawford Museum of Medical Progress and Stovall Hall of Health will not open this spring.

The three-building complex, situated on the banks of the Mississippi River in Prairie du Chien, is operated by the SMS Charitable, Educational and Scientific Foundation which is supported by contributions. It has completed 17 spring-to-fall seasons.

In recent years the Museum and Hall complex has operated at a major deficit, between $20,000 and $25,000 annually.

The CESF's Board of Directors decided the Foundation could no longer tolerate another deficit of that magnitude and voted to close the Museum complex unless alternative funding could be found.

The State Medical Society met with representatives from the State Historical Society on several occasions; however, the Historical Society declined to offer any assistance, citing severe state budget restrictions.

The SMS staff continues to search for other sources of revenue so that the historic landmark may open as usual this spring. However, the outlook now is not favorable. ■

should provide benefits for both inpatient and outpatient psychiatric medical services at the same level as applicable to all other covered professional services rendered by physicians."

11. (Monroe) Office Surgical Procedures Insurance

"RESOLVED, that the State Medical Society of Wisconsin urge all insurance programs to provide for specific payment for costs of supplies and equipment used in the course of surgical procedures performed in the physician's office."

12. (Winnebago) National Catastrophic Illness Insurance

"RESOLVED, that the State Medical Society of Wisconsin direct the American Medical Association delegates to pass legislation asking Congress to pass a bill covering catastrophic illness in the next session."

13. (Winnebago) Public Law 93-641

Asks that the State Medical Society "support in spirit and principle the plaintiff action of the North Carolina Medical Society against HEW with regard to Public Law 93-641 Health Manpower Act, an administrative law dealing with certificate of need and certain health systems agency regulations."

14. (Fond du Lac) Public Law 93-641

Asks that the SMS call for repeal of Public Law 93-641, "and oppose any substitute federal or state legislative measures which contain similar provisions. . . ."

15. (Withdrawn)

16. (Lincoln) Title XIX Fee Freeze

Asks SMS to "continue its legal action against the State of Wisconsin in an attempt to prevent the continuance of the fee freeze for Title XIX patients."

17. (Waukesha) Patients Compensation Fund

Asks that "the legislature be asked to protect these monies for the specific purpose delineated, and that purpose alone, and that they not be invaded for any extraneous purpose."

18. (Section on Ophthalmology) Medical Eye Care

Reaffirms the SMS policy "that only physicians licensed to practice medicine and surgery in all of its branches are qualified to prescribe or apply eye medications, and that any attempts by nonmedical practitioners to engage in such practice through legislative or administrative rulings in the State of Wisconsin be vigorously and actively opposed . . ."

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19. (Sheboygan) Psychiatric Medical Services

Asks that the SMS "affirm and support the standards of psychotherapy of the American Psychiatric Association, and vigorously oppose any attempt by psychologists or others, by legislation, to become primary providers of psychiatric medical care to the further detriment and fragmentation of man and society."

20. (First Councilor District Delegation) Electromyoneurographic Procedures and Examinations

Asks SMS "to request the State Board of Medical Examiners to investigate and take appropriate action in all cases involving the performance of electromyoneurographic examinations by persons who are not physicians licensed to practice medicine in all its branches."

21. (Wood) Telephone Transmission of Electroencephalograms (EEG)

Asks SMS to endorse the standards and position of the Wisconsin Neurological Society regarding electroencephalograms.

22. (Milwaukee) Physician Extenders, "Independent Practitioners," and Point of Entry into Health Care System

Asks that appropriate committees of the State Medical Society "continue to monitor closely physician assistants and other extenders to assure proper supervision and delegation of responsibility;" to maintain vigilance so that these people "function in accordance with applicable statutes;" and to "reaffirm its (SMS) conviction that patients are well advised to enter the health care system through physicians . . ."

23. (Milwaukee) Hospital Emergency Unit Abuse

Directs the SMS Committee on Evaluation of Delivery and Cost of Health Care "to undertake a prompt study of policies and practices in all areas related to the delivery and payment for care in hospital emergency units to isolate and define the causes of abuses . . ."

24. (Fond du Lac) Hospital Medical Care Costs

"RESOLVED, that the State Medical Society of Wisconsin and the AMA continue to cooperate with the Legislature and the Congress in the preparation of reasonable legislation where necessary to prevent abuses." Also resolves that "members of this Society cooperate in the prosecution of any physician engaged in fraudulent practices."

25. (Paul A Dudenhoefer, MD and John A Malone, MD, Milwaukee) Hospital Medical Records Completion

Asks the State Medical Society "to request the State Board of Medical Examiners to establish satisfactory completion of hospital medical records, when necessary, as a criterion for renewal of state licensure."

26. (Richland) High Cost of Continuing Medical Education

Directs the State Medical Society to "investigate the factors involved in the skyrocketing cost of medical meetings" and to "implement an expanded program with the State of Wisconsin through the two Wisconsin medical schools to provide CME programs that are of good quality, practical, at reasonable cost and easily accessible to all of the physicians of Wisconsin."

27. (Section on Public Health and Preventive Medicine) Home Health Care

Directs the State Medical Society to "not only reaffirm the traditional values in home care, but also actively

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develop new initiatives in cooperation with other interested parties to promote a wider utilization of the concept of home health care."

28. (Section on Dermatology) Depilatron Method of Hair Removal

Directs the State Medical Society "to go on record as not recommending or approving the use of the depilatron method for permanent hair removal." ■

Postscript on Patient Compensation Panels

To clarify the article on physician involvement in the Patient Compensation Panels, appearing in this issue on page 12, panel members for both the formal and informal panels are chosen by random selection from lists of medical providers in the State.

Several names are drawn, using a jury roller drum, and when the director of the panels is able to contact three people who are willing to serve, these names are given to the parties involved in the action, and they may strike or challenge the names of any of the potential panel participants. ■

Correction and Addition

In addition to the six-item legislative "liability" package approved by the Physicians Alliance Commission at its February 25 meeting, reported in this issue on page 12, the Commission also approved an amendment to Chapter 37 which provides that no more assessments be made for the Patients Compensation Fund when the Fund balance is $10 million or more. Present language says the Commissioner of Insurance *may* or may not assess any more fees at the $10 million level.

Regarding the SMS draft for simultaneous countersuit: the language provides that prior to granting a motion to dismiss an action which is deemed to have insufficient legal merit, the court may award actual costs and damages. The end result would be the same as in a simultaneous countersuit, but the approach differs. ■

Caucus Meetings

Four councilor districts have set meeting times and dates for their annual caucuses:

- 3rd district, March 21, Midway Motor Lodge, 5 pm caucus meeting, 6:30 pm dinner and councilor district meeting (all members).
- 8th district, March 23, Scottie Club, Ashland, 6:30 pm dinner and meeting.
- 2nd district, March 27, SMS offices in Madison, 1:30 pm.
- 4th district, March 28, Wausau Club, 4 pm meeting. ■

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MILWAUKEE	B. B. Becker	R. T. Adlam
	G. C. Bernhard	S. D. P. Altman
	D. C. Bruno	M. C. Collopy
	D. J. Carlson	J. W. Cornell
	A. C. Costello	S. A. Graziano
	P. A. Dudenhoefer	D. P. Collins
	C. P. Erwin	K. S. Fabric
	W. E. Finlayson	J. W. Fons, Jr.
	G. F. Flynn	M. T. Galang, Jr.
	H. R. Foerster, Jr.	M. T. Jaekels
	G. H. Franke	J. E. Geigler
	Marvin Glicklich	L. B. Glicklich
	T. F. Jennings	S. V. Hansen
	H. M. Kauffman	S. A. Korducki
	P. G. LaBissoniere	E. J. Drvaric
	R. E. Laubenheimer	H. W. Parker
	J. D. Levin	D. K. Dunn
	R. F. Madden	J. A. Chopyak
	J. A. Means, III	M. D. Poland
	J. P. Mullooly	R. E. Pollard
	G. V. Murphy	J. L. Grieshop
	A. R. Pequet	Louis Kagen
	R. B. Pittelkow	J. V. Pilliod
	Shimpei Sakaguchi	Richard Stone
	K. E. Sauter	B. H. Usow
	D. P. Schlueter	George Walcott
	J. T. Schmitz	S. F. Horwitz
	K. M. Smigielski	J. J. Sherry
	W. L. Treacy	J. D. Storey
	H. F. Twelmeyer	D. J. Welter
	Marvin Wagner	P. J. Taugher
	R. R. Watson	J. L. Teresi
	DeLore Williams	G. J. Topetzes
	J. F. Zimmer	Maxwell Weingarten
OZAUKEE	R. F. Henkle	J. E. Kippenhan
RACINE	L. R. Grinney	K. H. Kolmeier
	M. G. Parker	S. M. Englander
	W. J. Smollen	J. J. Veranth
WALWORTH	I. J. Bruhn	R. S. Galgano
WASHINGTON	C. S. Geiger, Jr.	Parnell Donahue
WAUKESHA	T. P. Belson	R. J. Darling
	R. P. Froeschle	J. C. Hanson
	T. A. Hofbauer	K. J. Dempsey
	G. D. Miller	M. A. Meyer
	J. D. Riesch	W. H. Konetzki
SECOND DISTRICT		
COLUMBIA-MARQUETTE-ADAMS	R. T. Cooney	M. L. Janssen
DANE	J. G. Albright	Sanford Mackman
	J. C. Allen	S. W. Boyer
	J. F. Batson	B. E. Stein
	M. A. Cunningham	P. P. Rank
	C. H. Geppert	C. L. Andringa
	E. E. Johnson	R. A. Graf
	T. C. Meyer	R. J. Hendricks
	J. N. Moore	C. A. Neuhauser
	V. W. Nordholm	Phillip Schoenbeck
	J. K. Scott	J. B. Davis
	R. W. Shropshire	W. J. Hisgen
	P. O. Simenstad	F. H. Koenecke, Jr.
	C. A. Taylor, Jr.	J. D. Kabler
	C. B. Weston	L. C. Bernhardt
DODGE	W. E. Funcke	F. A. Karsten
GRANT	S. J. Nuland	K. L. Bauman
GREEN	M. S. Blumenthal	J. E. Erlandson
IOWA	T. A. Correll	H. P. Breier
JEFFERSON	D. E. Bates	R. R. Liebenow
LAFAYETTE	L. L. Olson	N. A. McGreane
RICHLAND	J. J. Tydrich	R. W. Edwards
ROCK	Jordon Frank	R. M. Baldwin
	M. F. Purdy	A. L. Reinardy
	Vacancy	Vacancy
SAUK	I. A. Galarnyk	G. J. Holmen
THIRD DISTRICT		
CRAWFORD	E. M. Desslock	Vacancy
JUNEAU	V. M. Griffin	Jack Strong
LA CROSSE	D. B. Comin	Frederick Skemp
	J. T. Murphy	K. P. Grill
	C. A. Natoli	S. B. Webster
	D. W. Taehel	K. L. Newcomer
MONROE	J. S. Mubarek	P. G. Albrecht
TREMPEALEAU-JACKSON-BUFFALO	W. E. Wright	J. H. Noble
VERNON	R. A. Starr	T. E. Boston
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CLARK	B. O. Gungor	E. D. Pfefferkorn
FOREST	B. S. Rathert	E. F. Castaldo
LANGLADE	J. O. Moermond, Jr.	T. C. Fox
LINCOLN	N. L. Bugarin	J. S. Janowiak
MARATHON	G. R. Hammes	T. O. Miller
	J. D. Kramer	W. B. Rudy
ONEIDA-VILAS	H. J. C. Schwartz	W. E. Raduege
PORTAGE	P. K. Hacker	B. C. Palaganas
PRICE-TAYLOR	W. W. Meyer	Vacancy
WOOD	R. L. Hansen	W. J. Maurer
	R. L. Johnson	J. E. Thompson
	R. H. Ulmer	W. M. Toyama
	Vacancy	Vacancy
FIFTH DISTRICT		
CALUMET	R. D. Heinen	J. L. Jaeck
FOND DU LAC	J. T. Elliott	L. C. Fischer
	R. S. Pelton	B. H. Hartman
GREEN LAKE-WAUSHARA	R. A. Kjentvet	Roy Hong
OUTAGAMIE	M. K. Jasser	C. F. Dungar
	R. R. Kinde	R. W. Swanson
	R. H. Ward	K. N. Keane
WAUPACA	L. P. Maasch	D. M. Lochner
WINNEBAGO	G. W. Arndt	G. R. Anderson
	J. L. Basiliere	J. A. Mathison
	T. T. Flaherty	O. E. Larson
	K. M. Viste, Jr.	C. R. Lyons
SIXTH DISTRICT		
BROWN	J. E. Martin	L. D. Philipp
	W. E. McNeal	G. R. Kaftan
	C. W. Troup	J. A. McIntyre
	B. P. Waldkirch	Roger von Heimburg
DOOR-KEWAUNEE	J. J. Beck	D. E. Papendick
MANITOWOC	G. H. Stannard, Jr.	J. D. Lynch
MARINETTE-FLORENCE	C. E. Koepp	R. C. Murray
OCONTO	J. K. Theisen	C. E. Siefert
SHAWANO	W. W. Grover	J. J. Albright
SHEBOYGAN	J. B. Kuplic	I. L. Schroeder
	R. M. Senty	R. C. Pauly
SEVENTH DISTRICT		
BARRON-WASHBURN-BURNETT	J. L. Esswein	F. M. Bannister
CHIPPEWA	M. W. Asplund	J. J. Sazama
EAU CLAIRE-DUNN-PEPIN	R. F. Hudson	P. J. Happe
	K. E. Walter	Vacancy
	J. E. Willard	S. R. Lee
PIERCE-ST. CROIX	J. A. May	D. M. Woeste
POLK	Vacancy	M. E. Wegner
RUSK	J. E. Murphy	R. P. Bennett
EIGHTH DISTRICT		
ASHLAND-BAYFIELD-IRON	J. M. Jauquet	H. H. Larson
DOUGLAS	C. M. Scott	T. J. Doyle
SAWYER	M. H. Sahs	Vacancy
SECTIONS		
ALLERGY AND CLINICAL IMMUNOLOGY	J. J. Ouellette	S. R. Hirsch
ANESTHESIOLOGY	J. T. Small	W. J. Holtey
DERMATOLOGY	J. E. Taxman	H. V. Moss, Jr.
FAMILY PHYSICIANS	N. G. Bauch	J. O. Grade
INTERNAL MEDICINE	G. E. Owen	B. J. Haza
MEDICAL FACULTIES	Vacancy	R. A. Pattillo
NEUROLOGY	Francis Kruse, Sr.	Michael McQuillan
NEUROSURGERY	G. A. Meyer	F. C. Kriss
OBSTETRICS-GYNECOLOGY	W. E. Martens	R. P. Reik
OPHTHALMOLOGY	R. W. Pointer	T. W. Stram
ORTHOPEDICS	P. A. Jacobs	G. N. Guten
OTOLARYNGOLOGY	M. F. Kwaterski	Vacancy
PATHOLOGY	E. A. Burg, Jr.	R. E. Carlovsky
PEDIATRICS	R. L. Myers	W. H. Bartlett
PHYSICAL MEDICINE AND REHABILITATION	S. A. Spicuzza	J. A. Sladky
PLASTIC SURGERY	J. E. Hamacher	G. M. Tucker
PSYCHIATRY	D. A. Treffert	Craig Larson
PUBLIC HEALTH AND PREVENTIVE MEDICINE	G. P. Ferrazzano	Richard Biek
RADIOLOGY	R. C. Feulner	Vacancy
RESIDENTS	Vacancy	Vacancy
SURGERY	T. J. Beno	G. F. Pratt
UROLOGY	F. I. Andres	Raymond Harkavy

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of January 28, 1977

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

BARRON-WASHBURN-BURNETT

Rathbun, J M, Northern Pines Clinic, Cumberland 54829 (1946, Regular, Psychiatry)

BROWN

Cruz, Lorenzo R, 438 St Bernard Dr, DePere 54115 (1936, Regular, Therapeutic Radiology/ General Practice)

Geocaris, Thomas V, 618 Bordeaux Ave, Green Bay 54301 (1942, Regular, General Surgery/Cardiovascular Surgery, Certified)

Hable, Jane, 1751 Deckner Ave, Green Bay 54302 (1943, Regular, Family Practice, Certified)

Samuels, David P, 900 S Webster St, Green Bay 54301 (1944, Regular, Pediatrics, Certified)

DANE

Cripps, Derek J, 1300 University Ave, Madison 53706 (1928, Regular, Dermatology/Internal Medicine, Certified-D)

Demling, Robert H, 1300 University Ave, Madison 53706 (1943, Regular, General Surgery)

Hoff, Brian H, 1300 University Ave, Madison 53706 (1943, Regular, Anesthesiology, Certified)

Richter, James J, 1300 University Ave, Madison 53706 (1944, Regular, Anesthesiology)

Speichinger, James P, 20 S Park St, Madison 53715 (1945, Regular, Obstetrics and Gynecology)

DODGE

Ali, Mohammed A, 130 Warren St, Beaver Dam 53916 (1941, Regular, General Surgery, Certified)

LACROSSE

Westgard, David E, 815 S 10th St, LaCrosse 54601 (1945, Regular, Family Practice, Certified)

MARATHON

Dernbach, William K, 400 E Thomas St, Wausau 54401 (1944, Regular, Internal Medicine)

Foltz, Alexander S, 630 First St, Wausau 54401 (1943, Regular, Orthopedic Surgery)

Groth, Boyd J, Mosinee Medical Facility, Mosinee 54455 (1943, Regular, General Practice)

Kanemoto, Henry H, 400 E Thomas St, Wausau 54401 (1943, Regular, Radiology/Diagnostic Radiology, Certified-R)

Oh, Shenton M, 400 E Thomas St, Wausau 54401 (1946, Regular, Anesthesiology)

Pietz, Wayne J, 400 E Thomas St, Wausau 54401 (1946, Regular, Internal Medicine)

MILWAUKEE

Bakaleinik, Maurice, 8410 W Cleveland Ave, Milwaukee 53227 (1915, Regular, General Surgery, Certified)

Diba, Ali A, 3201 S 16th St, Milwaukee 53215 (1941, Regular, Internal Medicine/Gastroenterology, Certified-IM)

Jona, Juda Z, 411 E Mason St, Milwaukee 53202 (1940, Regular, Pediatric Surgery/General Surgery, Certified-GS)

Mintz, Stephen M, 1220 Dewey Ave, Milwaukee 53213 (1948, Resident, Obstetrics and Gynecology)

Mullins, Margaret M, 100 15th Ave, South Milwaukee 53172 (1945, Regular, General Practice)

Reeder, Tilden B, 155 E Silver Spring Dr, Milwaukee 53217 (1946, Regular, Psychiatry/Child Psychiatry)

Sleight, Douglas R, 3533 E Ramsey Ave, Cudahy 53110 (1943, Regular, General Surgery, Certified)

Warsh, James R, 11622 W North Ave, Wauwatosa 53226 (1945, Regular, Anesthesiology)

RACINE

Bahzad, Christobel G, 2405 Northwestern Ave, Racine 53404 (1947, Regular, Obstetrics and Gynecology)

Hirsh, S Jay, 2405 Northwestern Ave, Racine 53404 (1944, Regular, Urology)

Klein, Karl J, 5625 Washington Ave, Racine 53406 (1944, Regular, Obstetrics and Gynecology)

Martin, Carroll M, 5625 Washington Ave, Racine 53406 (1939, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)

Qazi, Mohammad H A, 1320 Wisconsin Ave, Racine 53403 (1947, Regular, Radiology/Nuclear Medicine, Certified-R)

ROCK

Gordon, Michael C, 320 Lincoln St, Janesville 53545 (1943, Regular, Family Practice)

SHAWANO

Harms, Ronald L, 117 E Green Bay St, Shawano 54166 (1945, Regular, Family Practice, Certified)

Stoughton, Richard R, 117 E Green Bay St, Shawano 54166 (1937, Regular, Family Practice)

WAUKESHA

Pearce, Jan D, 17050 W North Ave, Brookfield 53005 (1944, Regular, Radiology)

Phillips, John R, 890 Elm Grove Rd, Elm Grove 53122 (1944, Regular, Orthopedic Surgery)

WINNEBAGO

Baltz, Curtis C, 960 Bridgewood Dr, Neenah 54956 (1947, Regular, Internal Medicine)

Bandow, Paul W, 825 N Westfield St, Oshkosh 54901 (1940, Resident, Psychiatry)

Darr, David L, 318 Joseph St, Neenah 54956 (1945, Regular, Obstetrics and Gynecology)

Geller, Kenneth A, 209 Stevens St, Neenah 54956 (1947, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)

Sanzenbacher, Larry, 400 Ceape Ave, Oshkosh 54901 (1941, Regular, General Surgery, Certified)

Woodruff, Roland N, 650 Doctors Park, Oshkosh 54901 (1945, Regular, Internal Medicine, Certified)

WOOD

LeTellier, Marc A, 1000 N Oak Ave, Marshfield 54449 (1944, Regular, Neurological Surgery)

Tan, Thien S, 1000 N Oak Ave, Marshfield 54449 (1942, Regular, Diagnostic Radiology/Radiology)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DANE

Ansfield, Fred J, Clam Lake, to 2266 N Prospect Ave, Milwaukee 53202

Hussey, John L, Middleton, to RR 2 Hwy P No 4274, Cross Plains 53528

EAU CLAIRE-DUNN-PEPIN

Ivsin, Olga, Eau Claire, to 3322 S Calumet Ave, Chicago, IL 60616

MILWAUKEE

Kim, Zaezeung, Milwaukee, to 1701 Douglas Ave, Racine 53404

ONEIDA-VILAS

Lindahl, Stephen A, Rhinelander, to PO Box 346, Hudson 54016

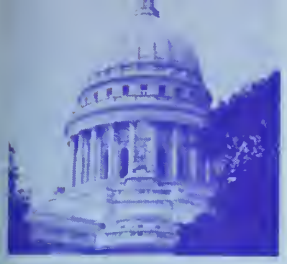
RACINE

Ivsin, Rostislav, Sturtevant, to 150 East Dekora St, Saukville 53080

WAUKESHA

Varma, Som D, Oconomowoc, to 929 North Astor St, Milwaukee 53202

Continued on page 21



CAPITOL WEEK

A Review of Health Care Activities in Wisconsin State Government.

March 3, 1977

SPECIAL EDITION!

For your reference, here is a listing of all the major health-related legislative proposals introduced thus far in the 1977-78 session of the Wisconsin Legislature. Included in each bill listing is (1) bill number; (2) summary of the bill; (3) first named author; (4) committee to which it was referred; and (5) the SMS position if a position has been taken. The SMS Governmental Affairs Commission will meet soon to take a position on the bills which are starred (*).

The Physicians Alliance Division of the State Medical Society is following an additional 100 bills which have been introduced into this session. These measures have no direct impact upon physicians, but are of interest to physicians.

SENATE BILLS

SB 23 Bill directs the commissioner of insurance to promulgate rules establishing minimum standards for disability insurance policies designed to supplement the federal medicare insurance program. *(Cullen) (Agriculture, Aging & Labor)*

SB 29 Creates in the department of administration a division of welfare inspector general to investigate welfare frauds and abuses. Division is headed by a welfare inspector general who is in executive salary group 2. *(Petri) (Human Services)*

SB 30 Permits counties to consolidate their departments of public welfare in order to improve administrative efficiency. Consolidations must be approved by the secretary of health and social services and by all counties involved. *(Petri) (Human Services)*

SB 31 Requires state and county employes working with public assistance program to ensure that applicants obtain all available aid from federal programs before being granted state aid. *(Petri) (Human Services)*

SB 32 Requires that determinations of eligibility for food stamps, general relief, medical assistance and aid to families with dependent children include consideration of "in-kind income" which includes all assistance from any public assistance agency or program. *(Petri) (Human Services)*

SB 33 Requires recipients of aid to families with dependent children to pick up their aid in person. Bill also requires all family members over the age of 16 to have employment counseling by the department on a monthly basis. Requirements do not apply to person who suffer a disability. *(Petri) (Human Services)*

SB 34 Requires every recipient of aid to families with dependent children who is over the age of 16 to be examined and classified for employability before aid can be granted. Recipients are presumed employable and must prove that they are unemployable because of illness, significant incpacitation, age, fulltime school attendance (if under 21) full-time attendance in a vocational training program, or full-time child care. A person classified as employable may not recieve aid unless he/she has registered with the state employment service and obtains a certificate from the service at least twice each month which states that there are no job openings for which the recipient is eligible. Recipient may not refuse to take a job or willfully perform a job inadequately. *(Petri) (Human Services)*

SB 35 Requires recipients of medical assistance to contribute to the cost of their medical care. Also directs the department of health and social medical expenses which exceed the average customary cost for that type of service. *(Petri) (Human Services)*

SB 36 Requires the department of industry, labor and human relations and agencies administering aid to families with dependent children to establish public work projects whereby aid recipients are required to perform services for governmental units or nonprofit agencies. *(Petri) (Human Services)*

SB 37 Requires adult children of parents who are unable to support themselves to contribute to their parent's maintenance. Bill specifically provides that such a duty of support arises whenever a dependent person lives within this state, and the relatives who may legally be held liable for support are responsible even if they are not Wisconsin residents. *(Petri) (Human Services)*

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SB 39 Limits the amount of property which may be owned by a recipient of public assistance to $1,200 in household effects ($600 for a recipient of aid to families with dependent children), $20,000 in residential property, $1,500 in motor vehicles necessary for employment and $1,000 in other property. *(Petri) (Human Services)*

SB 40 Requires applicants for aid to families with dependent children to reveal all assets and document their income and economic status to the satisfaction of the department of health and social services. *(Petri) (Human Services)*

SB 41 Requires that recipients of aid to families with dependent children appear in person to be recertified as eligible for aid every 6 months. Department of health and social service must conduct a new investigation and make a determination of eligibility and grant size each time a recipient appears for recertification. *(Petri) (Human Services)*

SB 42 Sets a limit of $50 for work-related expenses plus $50 for work-related child care costs which may be deducted from an applicant's salary in determining eligibility for aid to families with dependent children. The bill also requires reduction of aid on a monthly basis when the recipient receives extra income. *(Petri) (Human Services)*

SB 43 Requires county departments of public welfare to provide public assistance recipients with individual photo identification cards which the recipients must then carry and present in order to receive services. *(Petri) (Human Services)*

SB 44 Requires that eligibility for aid to families with dependent children be determined independently of grant size. Only criteria which may be considered in eligibility determination are the applicant's need and income. *(Petri) (Human Services)*

SB 45 Requires employable recipients of aid to families with dependent children to pick up their assistance checks in person and to participate in employment counseling and accept job referrals as required by the agency granting aid. *(Petri) (Human Services)*

SB 56 Bill makes several changes in laws concerning the regulation of the nursing profession: (1) Resident aliens are permitted to become registered nurses & trained practical nurses, as well as be appointed administration of the division of nurses, (2) administrator is required to have at least a master's degree, (3) if registered nurse graduated from an accredited school of nursing outside of Wisconsin, the school must have a required curriculm equivalent to that required in this state, (4) board of nursing is granted investigatory powers, including power to issue administrative subpoenas and power to require physical or mental examinations, (5) administrator's authority to establish rules is repealed & authority is vested solely with board of nursing, (6) applicants for registered nurses examination are required to be in good physical & mental health, (7) authority of board to revoke, suspend or deny renewal of registration for violation of a board rule is specifically stated, (8) function of designating the time and place for licensed practical nurse examinations is transferred from board of nursing to examining council on licensed practical nurses, (9) fine for violations of nursing laws is increased from $250 to $1,000, (10) department of justice is directed to represent board in seeking an injunction when requested by board. Bill also clarified statutory language regarding nurse's exemption from civil liability for refusal to assist in sterilization or abortion procedures on religious and moral grounds. **SMS deferred action.**

SB 57 Bill increases number of persons who are required to report instances of suspected child abuse to include chiropractors, coroners, medical examiners, podiatrists, peace officers and certain personnel in schools, child care facilities and child welfare agencies. Also requires reporting in certain cases where child appears to be neglected. Increases penalties such that violators may be fined not more than $5,000, imprisoned not more than one year. Bill provides a mechanism for emergency protection of an abused, injured or neglected child which allows department of health and social services to take custody of child on a temporary basis not to exceed 48 hours, or 72 hours on a weekend or holiday. *(Petri) (Consumer Affairs)* **SMS supports principle.**

SB 76 Bill provides that communications between a psychologist and a patient are privileged as are communications between a doctor and a patient. *(Judiciary & Consumer Affairs)* **SMS - no position.**

SB 107 Bill revises statutory definition of "optometry." Principal change is to allow optometrists to use pharmaceutical agents for diagnostic purposes. *(Human Services)* **SMS opposes.**

SB 108 Bill requires that contracts of health insurance provide equal coverage for services of both chiropractors and physicians, rendered within the scope of their respective professional licenses. *(Commerce)* **SMS opposes.**

***SB 122** Bill requires an autopsy where a child under age 4 dies and sudden infant death syndrome is suspected. Also directs department of health and social services to establish informational and counseling programs to aid families of sudden infant death syndrome victims. *(McKenna) (Human Services)* **SMS position deferred.**

***SB 155** Bill changes certain present criminal penalties for "simple" possession or nonprofit transfer of marijuana or its derivatives. *(Risser) (Judiciary and Consumer Affairs)*

SB 158 Bill amends S. 971.17 (1) to provide for automatice commitment only when there is an additional finding that a defendant continues to suffer from the mental disease or defect and, therefore, is in need of institutional care. *(Legislative Council) (Judiciary and Consumer Affiars)*

SB 165 Gives a cause of action to the department of health and social services and any county or municipality providing public assistance benefits as a result of the occurrence of injury, sickness or death as to which a possible recovery or indemnity from a 3rd party may be available. The department, county or municipality may make a claim or maintain an action in tort against such a 3rd party, and may require the recipient or applicant to assign the claim in order to receive benefits. *(Human Services)*

SB 169 Bill authorizes counties, cities, towns and villages to borrow money to finance the construction of medical clinics. *(Radosevich) (Human Services)*

SB 191 Creating a council on opthalmic dispensing. *(Commission on Human Services)*

ASSEMBLY BILLS

AB 1 Bill prohibits the university of Wisconsin system and the medical college of Wisconsin, inc., from giving preference to any appliciant because of a financial contribution made or promised to be made by or on behalf of the applicant. *(Rogers) (Education)*

AB 35 Bill creates in the Department of regulation and licensing a division of health services. The division of nurses is abolished and a new health services board is created and attached to the division of health services. Examining boards transferred to the division include: chiropractic, dentistry, hearing aid dealers, medical examining board on nursing, nursing home administrators, optometry, pharmacy, psychology, and the pharmacy intership examining board. The bill creates a health services tax applicable to all persons based upon income ranging from 5% of those with taxable incomes of less than $5,000 per year to 100% of taxes paid for incomes of $70,000 or more. The division of health services would have the authority to hire and set salaries of all health care providers in the state. It establishes a committee to develop a plan for state ownership of all hospitals, clinics, and nursing homes and other health care facilities with reimbursement to present owners. *(Coggs) (Health and Social Services)* **SMS opposes.**

AB 56 Bill makes several changes in the public assistance laws including: (1) mandatory penalties for persons willfully making false representations to secure public assistance, (2) application for general relief or aid to families with dependent children must be made in person and such aid must be paid at the county agency or other county office, unless a physicians submits a written statement that a person is unable to comply with or would be adversely affected by these requirements, (3) no AFDC payments would be allowed if the father is a full-time student, (4) AFDC payments presently may include fuel and utility supplementation. Payments are limited to family size, (5) counties may recover AFDC payments continued to a person pending a hearing, if the person is unsuccessful at the hearing. *(Klicka) (Health and Social Services)*

AB 81 Bill adds a podiatrist member to medical examining board and prohibits all members of examining board from being an instructor or financially interested in a school of podiatry. *(Dorff) (State Affairs)* **Hearing held SMS opposes.**

AB 94 Bill permits first cousins to marry upon submission to the county clerk of an affidavit signed by a physician stating that one party is sterile. *(Thompson) (Judiciary)*

AB 96 Bill repeals special "good Samaritan" (Licensed physicians podiatrists, physical therapists, physician's assistants and registered nurses are not civilly liable for any "good faith" acts or omissions in rendering emergency care at the scene of an emergency or accident) immunity for such professionals and creates a general "good Samaritan" law applicable to all persons who render emergency care at the scene of an emergency or accident in good faith and within the range of their professional competence. *(Rooney) (Judiciary)* **SMS no position.**

AB 110 Bill provides that if, after receiving the results of special examination, the administrator denies the person's application, the applicant may request in writing that the denial be reviewed by a reviewing board. Review Boards will consist of the adminstrator or administrator's representative and 2 members appointed by the administrator from a list of physician and optometrists licensed to practice in this state. Optometrists are limited to cases concerning vision. *(Groshek) (Transportation)* **Hearing held - See AB 221.**

AB 119 Bill authorizes an employee covered by workman's compensation to select any attending physician, podiatrist or chiropractor; current law requires the employee to select the practitioner from a panel named by the employer. DILHR currently has the authority to permit the selection of a practitioner outside the panel or to have its own selected practitioner outside the panel or to have its own selected practitioner if the employer's practitioners are prejudiced. Under the bill, an employee would also be able to select a second practitioner (paid by the employer if a dispute exists over the employee's ability to return to work). *(McClain) (Labor)* **SMS - no position.**

AB 123 Bill eliminates restriction of sale of aspirin, includes retail stores to sell plain aspirin. *(McClain) (Commerce and Consumer Affairs)* **Passed Assembly 96-0. SMS supports.**

AB 136 Bill requires that an abortion certificate be filed after each induced abortion performed in this state. State registrar of deeds must file and permanently keep these certificates. Copy of any abortion certificate will be made available upon court order. *(Lewis) (Health and Social Services)* **SMS - no position.**

AB 137 Requires the state registrar to record on the birth certificate the death of any person less than 5 years of age whose birth was registered in this state. *(Lewis) (State Affairs)*

AB 148 Bill would increase the number of persons required to report instances of suspected child abuse to include chiropractors, coroners, medical examiners, podiatrists, physician's assistants, physical therapists, psychologists, child welfare agency employees, and school teachers. Proposes to increase penalties for persons who knowingly and willfully fail to report such cases to not more than $5,000 and imprisonment for not more than one year in the county jail or both. Allows for emergency protection of an abused or neglected child by allowing the department of health and social services to take custody on a temporary basis not to exceed 48 hours or 72 hours on weekend or holiday. An optional commitment procedure for presentence examinations is provided for in the bill and courts would have the option of committing persons who are convicted of child abuse to the department of health and social services for a presentence social and psychological exam. *(Czerwinski) (Criminal Justice and Public Safety)* **SMS supports in principle.**

AB 159 Bill requires insurers and cooperative associations providing health and accident coverage to allow free choice of services of licensed psychologists if they provide coverage for such services when performed by physicians. Bill also provides coverage for such services by medical assistance programs. Bill also provides that diagnostic and therapeutic psychological services may be performed without physician supervision or referral. *(Ferrall) (Health and Social Services)* **SMS opposes**

AB 160 Bill provides that communications between a psychologist and a patient are privileged as are communications between a doctor and a patient. *(Czerwinski) (Judiciary)* **Hearing held - SMS no position.**

*** AB 193** **See SB 122.**

AB 194 Bill creates a catastrophic illness insurance plan whereby persons incurring heavy medical expenses may obtain state aid in meeting their abnormally large financial responsibilities. Funds for administering the program and for making aid payments would come from general program revenues and taxes paid by insurance companies. Bill also directs commissioner of insurance to establish a mandatory health insurance risk sharing plan for the family of persons with a gross income of 175% or less of the maximum income allowed in determining eligibility for medicaid and for the family of persons unable to obtain health insurance coverage in the voluntary market because of medical underwriting or policy exclusions. All health insurance providers are required to participate and share costs in proportion to the volume of health insurance written on person in this state. Bill also requires disability insurance policies to provide minimum levels of benefits. Minimum levels are to be set by rule of commissioner. **Hearing held - SMS supports.**

AB 195 Bill requires disability insurance policies to provide minimum levels of benefits. Minimum levels are to be set by rule of the commissioner of insurance. **Hearing held - SMS supports.**

AB 196 Bill directs the commissioner of insurance to establish a mandatory health insurance risk sharing plan for a family with a gross income of 175% or less of the maximum income allowed in determining eligibility for medicaid and for the family unable to obtain health insurance coverage in the voluntary market because of medical underwriting or policy exclusions. *(Czerwinski) (Health and Social Services)* **Hearing held - SMS supports.**

AB 197 Bill permits licensed embalmers and surgical technicians who have completed a course in the removal of eyes approved by the department of health and social services to remove donated eyes from corpes. *(DeLong) (Health and Social Services)* **SMS supports with DeLong's amendment, deleting "Surgical Technicians".**

AB 209 Bill would set a mandatory minimum sentence of 2 years for persons convicted by delivering narcotics and for adults who distribute narcotics to minors at least 3 years younger than they. *(Behnke) (Criminal Justice and Public Safety)* **SMS no position.**

AB 221 Bill provides that if, after receiving the results of the special examination, the administrator for a drivers license of motor vehicles denies the person's application, the applicant may request in writing that the denial be reviewed by a reviewing board. Review boards will consist of the administrator or the administrator's representative and 2 members appointed by the administrator from a list of physicians and optometrists licensed to practice in this state. Optometrists are limited to cases concerning vision. *(Croshek) (Transportation)* **Hearing held - SMS supports.**

AB 222 Bills repeals requirement of the use of protective headgear and eye protection when operating or riding upon a motordriven cycle and prohibits persons from renting motordriven cycles to another unless the person has the headgear and eye protection. *(Clarenbach) (State Affairs)* **SMS opposes repeal.**

AB 237 Under bill, if a court, upon judgment determines that an action, special proceeding, counterclaim or cross complaint is frivolous, the court will be required to award reasonable court costs and attorney fees to the successful party. Costs and fees may be assessed fully against either the unseccessful party or his/her attorney or assessed to require partial payment by both the party and the attorney. *(Hanson) (Judiciary)* **SMS supports.**

AB 240 Bill authorizes medical facilities and medical personnel to adminster laetrile and permits laetrile to be prepared and sold to anyone in this state without prescription. *(Lewis) (Health and Social Services)* **SMS deferred position pending review by Cancer Committee.**

AB 250 Bill deletes from the rule-making authority of the secretary of health and social services in regard to community mental health, mental retardation, alcoholism and drug abuse services the following powers: Prescribing standards for qualifications and standards of personnel, prescribing requirements for in-service and educational leave programs for personnel, prescribing standards for establishing patients' fee schedules and such other standards and requirements as may be necessary to carry out the purposes of this law. *(Gower) (Health and Social Services)*

AB 270 Bill requires the department of health and social services to reimburse towns on a per call basis for ambulance service provided on federal, state and county highways until the total amount of fees paid to the town equals the amount the town has expended to comply with the department's standards. *(Olson) (Local Affairs)*

AB 281 Bill revises the statutory definition of "optometry". The principal change other than refinements in light of current technology is to allow optometrists to use pharmaceutical agents for diagnostic purposes. Bill requires optometrists to demonstrate competency in the use of such agents before using them. *(Health and Social Services)* **SMS opposes.**

AB 283 Bill would permit optometrists and opticians to advertise the price of glasses, frames, lenses and fitting and sets certain advertising requirements. Requires the optometry examining board to set minimum quality standards for contact lenses, lenses, frames and complete glasses to assure that inferior materials are not advertised or sold. *(Norquist) (State Affairs)*

AB 299 Bill creates a council in infant health screening in the department of health and social services. Council has 2 public members, 2 members who are doctors and one member appointed by the secretary of health and social services. Council is to study the feasibility of testing newborn infants to discover diseases which cause metabolic disorders. Requires every doctor to do a blood test on every newborn for diseases causing metabolic disorders. *(Czerwinski) (Health and Social Services)* **Hearing held - SMS supports with amendments.**

AB 318 Bill raises the drinking age to 19. Also raises the age at which one may obtain various beer and liquor licenses to 19. *(Johnston) (Judiciary)*

AB 325 Bill changes certain present criminal penalties for the "simple" possession or nonprofit transfer of marijuana or its derivatives. A person who possesses marijuana or concentrated cannabis in a public place or who transfers those substances without intent to profit to another person would be subject to a mandatory forfeiture of not more than $50. "Simple possession of marijuana or concentrated cannabis in a nonpublic place would not be either a crime or subject to forfeiture. Counties, cities and villages are authorized to adopt ordinances prohibiting "simple" possession or nonprofit transfer of marijuana. *(Clarenbach) (Health and Social Services)*

AB 369 Bill excludes hospital exemptions from property tax. *(Ward) (Joint Survey Committee on Tax Exemptions)*

AB 418 Hospital Patients Bill of Rights. *(Clarenbach) (Commerce and Consumer Affairs)*

AB 425 Requiring Insurance Coverage of Outpatient Psychiatric Medical Services. *(Ward) (Insurance & Banking)*

AB 426 Creating a council on Hemophilia and related blood disorders with a program of financial assistance. *(Vanderperran) (Health and Social Services)*

SPECIAL LEGISLATIVE NOTES

CERTIFICATE OF NEED -- 5 certificate of need (CON) bills, only one of which has actually been introduced, are waiting in the Senate and Assembly wings of the State Capitol. The Governor's budget bill, SB 77, contains provision for CON for capital expenditures in excess of $100,000 or any expenditures (regardless of amount) that would result in substantial change in service or bed capacity of the "health facility." The latter term is defined in this bill to include physician's offices and equipment. In addition, the Governor's proposal contains a "service licensing" provision to allow the Division of Health Policy and Planning to review and relicense periodically all existing services in health care facilities on the basis of their continuing appropriateness in light of changing health care needs. The Division, using service licensure authority, could also require facilities to offer certain services that are needed by a community but are not being provided. Even though the Governor's proposal limits the application of capital expenditure review to those in excess of $100,000, it also gives the State Department of Health and Social Services the authority to write rules for projects that cost less than $100,000.

Four other CON bills not yet introduced take varying approaches to the same subject. These bills have not been introduced because legislative leaders are seeking to develop a single "agreed" bill out of the committee process.

SB 77 -- the Governor's 1977-79 budget bill--covers total government operations for the biennium and will be reported separately in a subsequent **Capitol Week** issue because of its many implications for health care. In addition to the CON proposal mentioned above, this bill creates 4 positions to staff a health economics analysis unit to evaluate the economics of health care and "propose fee schedules for Title 19 Medical Assistance providers;" provides $302,000 for expansion of certified home health agencies; continues for one year an independent medical review contract with WHCRI; eliminates the Division of Health multiphasic screening program for an estimated savings of $284,000; proposes transfer of medical assistance claims administration from Blue Cross-Surgical Care and WPS to the State of Wisconsin; sets up a voluntary second opinion program for elective surgery, plus a preadmission testing and admission certification program for hospital patients; adds 5 positions to increase prior authorization reviews; 7 positions to decrease and prevent program abuse, and 6 positions to pursue third party liability under Title 19.

In addition, the Governor's budget will require physician referral for certain services such as psychotherapy, impose more limitations on availability of Title 19 services, require that nursing home administrators "countersign" any physician or other provider claims for services to nursing home residents, and that services to nursing home patients will be reimbursable only if they were anticipated in a patient plan of care.

COUNCIL ACTS ON CERTIFICATE-OF-NEED

The SMS Council, at a special meeting March 5, unanimously approved the concept and conditions of a change in the Society's legislative approach to Certificate-of-Need, particularly as it affects physicians' offices. The Council acted after hearing a report on the SMS Governmental Affairs Commission's nine-month in-depth review of the various certificate-of-need laws currently in place in 32 other states as well as an analysis of current and proposed federal regulations on the subject.

All members of the State Medical Society were sent a report of this Council action on March 7, with a brief explanation of CON and the Society's new legislative position. A more detailed review of CON, as presented to the Council, is available for county society meetings and councilor district caucuses.

COUNTY-TO-COUNTY TRANSFER

Ashland-Bayfield-Iron to Portage: Shaw, Henry H, 2501 Main St, Stevens Point 54481

Brown to Chippewa: Cook, Frederick D, 1315 Ridgewood Dr, Chippewa Falls 54729

Brown to Marientte-Florence: Eckstrom, Philip T, Rte 1, Box 254, Peshtigo 54157

Dane to Marathon: Barnes, Haldor P, 5714 Odana Rd, Madison 53711

Dane to Jefferson: Turke, Terry L, 123 Hospital Drive, Watertown 53094; Wilson, Douglas D, 123 Hospital Drive, Watertown 53094

Dane to Wood: Wilson, Janet A, 400 Dewey St, Wisconsin Rapids 54494

Jefferson to Columbia-Marquette-Adams: Diancin, Renato C, 545 Dix St, Columbus 53925

Milwaukee to Eau Claire-Dunn-Pepin: Enders, Gene G, 1415 Wilson Ave, Menomonie 54751

Milwaukee to Racine: Howell, Arthur, 1927 Washington Ave, Racine 53403; Kim, Zaezeung, 1701 Douglas Ave, Racine 53404

Trempealeau-Jackson-Buffalo to Milwaukee: Aprahamian, Charles, Div of Surgery, 8700 W Wisconsin Ave, Milwaukee 53226

DEATHS

Bourget, Gerald E, Eau Claire-Dunn-Pepin County, Jan 2, 1977

Barr, Arnold H, Ozaukee County, Jan 14, 1977

Frederick, Roland H, Milwaukee County, Jan 15, 1977 ■

OBITUARIES

◈County, State, AMA Members

◈ **Howard W Christensen, MD,** 70, Wausau, died Nov 17, 1976 in Wausau. Born Aug 10, 1906, Doctor Christensen graduated from the University of Wisconsin Medical School, Madison, in 1933 and practiced in Wausau from 1963 until his retirement in May 1974. Surviving are his widow, Elizabeth; a daughter, Mrs Nancie Brodhead, New York; two sons, Dr Richard, Phoenix, Ariz; and Howard, Madison.

◈ **Carlton J Ryan, MD,** 76, former Wisconsin Dells physician, died Nov 30, 1976 in Tomah. Born Nov 5, 1906 in St Paul, Minn, Doctor Ryan graduated from Marquette University School of Medicine, Milwaukee, in 1925. He had been on the executive committee of St Joseph's Hospital, Marshfield, and he was chief of Outpaient Services of the Veterans Administration Hospital, Tomah, from 1963-1973 when he retired. Surviving are his widow, Elvira; one daughter, Barbara, Madison; and two sons, Patrick, Minot, ND; and Dennis, Mt Pleasant, Mich.

Joseph Tschetter, MD, 76, Whitehall, died Dec 18, 1976 in Whitehall. Born June 11, 1900 in Bridgewater, SD, Doctor Tschetter was a 1931 graduate from the University of Illinois Medical School. Surviving is his widow, Leone, Whitehall. ■

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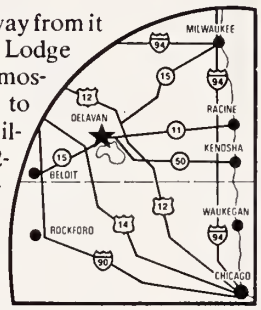

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Milwaukee Exposition & Convention Center & Arena (MECCA)

500 West Kilbourn Avenue, Milwaukee, WI

General Information

Registration. Pick up your badge at the Registration Desk, First Floor, MECCA, Friday, 8 a.m. - 5 p.m.; Saturday, 8 a.m. - 3:30 p.m. **Admittance by badge only!**

Meal Functions. Ticket orders accepted only thru April 8. **NO REFUNDS ON TICKETS AFTER APRIL 1!**

Business Sessions & Related Meetings

Key: Milwaukee Exposition & Convention Center & Arena (MECCA)
Marc Plaza Hotel (MP)

Program Committee:
George L. Lucas, MD, Chairman, Madison
Donald C. Whitenack, MD, La Crosse

Telephone Service: Special phones will be installed at the Registration Desk, 1st floor, MECCA, through which you can be reached if you are attending the scientific program. These numbers are:

414-765-1501
414-765-1502

The telephone number of MECCA is 414-271-4000.

Thursday, April 14, 2 to 4 p.m.

Convention Reception
Milwaukee County Historical Society Museum
910 North Third Street

Featuring the circa 1900 Doctor's Office, a bicentennial project of the Medical Society of Milwaukee County and its Auxiliary.

Sponsored by the Milwaukee County Auxiliary and the Aesculapian Society.

The Charitable, Educational & Scientific Foundation of the State Medical Society of Wisconsin acknowledges with appreciation grants made to it by:

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for continuing education of physicians. Under the direction of the Foundation, these grants have been utilized for support of the scientific program of the 1977 Annual Meeting of the State Medical Society.

House of Delegates

The House of Delegates meetings are regarded as among the most important functions of the Society. Reports of the officers and committees, as well as new business, will be presented at the initial session on Thursday, April 14. Reference committees will meet Thursday evening, with reports to be made at the Friday afternoon session. The third session, with election of officers, and installation of the President, will be held on Saturday morning.

Society members are urged to participate in the discussions on reports and resolutions in the open hearings of the reference committees.

SCHEDULE

Milwaukee Exposition & Convention Center & Arena - (MECCA)

The Marc Plaza - (MP)

THURSDAY, APRIL 14

10:30 a.m. SMS Specialty Sections Delegates Caucus Meeting: (MP)

1:00 p.m. House of Delegates Registration: (MECCA)

2:00 p.m. First Session, House of Delegates: (MECCA)
Nominating Committee (Location to be announced upon adjournment of House of Delegates session)

7:30 p.m. Reference Committees: (MP)
Resolutions and Amendments
Reports of Standing Committees
Reports of Officers
Finance

7:30 p.m. Opening Hearing of AMA Delegates: (MP)

FRIDAY, APRIL 15

3:00 p.m. House of Delegates Registration: (MECCA)

4:00 p.m. Second Session, House of Delegates: (MECCA)

SATURDAY, APRIL 16

7:30 a.m. House of Delegates Registration: (MECCA)

8:00 a.m. Third Session, House of Delegates: (MECCA)

THURSDAY, APRIL 14

9:00 a.m. Breakfast & Meeting: Board of Directors Wisconsin Academy of Family Physicians (Picasso-MP)

10:30 a.m. Section Delegates Caucus (Rembrandt-MP)

1:00 p.m. Registration House of Delegates (W. Octagon-MECCA)

2:00 p.m. 1st Session House of Delegates (W. Octagon-MECCA)

2:00 p.m. Milwaukee County Auxiliary & Aesculapian Society Convention Reception (Milwaukee County Historical Society Museum)

6:00 p.m. Buffet Dinner* (by ticket) (Empire-MP)

7:30 p.m. Open Hearing AMA Delegates (MP)

7:30 p.m. Reference Committee Meetings (MP)

FRIDAY, APRIL 15

7:15 a.m. Medicine & Religion Breakfast; Catholic Physicians Guild* (Regency-MP)

7:30 a.m. WISPAC Breakfast & Board Meeting (E-4/MECCA)

9:00 a.m. Morning Plenary Sessions (MECCA)

12:15 p.m. Socio-Economic Luncheon* (West Hall, 1st floor-MECCA)

1:45 p.m. Afternoon Plenary Sessions (MECCA)

3:00 p.m. Registration House of Delegates (W. Octagon-MECCA)

4:00 p.m. 2nd Session House of Delegates (W. Octagon-MECCA)

6:30 p.m. Presidents' Reception* (Crystal Ballroom Foyer-MP)

7:30 p.m. Presidents' Dinner* (Crystal Ballroom-MP)

SATURDAY, APRIL 16

7:30 a.m. Registration House of Delegates (W. Octagon-MECCA)

8:00 a.m. 3rd Session House of Delegates (W. Octagon-MECCA)

9:00 a.m. Morning Plenary Sessions (MECCA)

10:30 a.m. Council Meeting (Monarch-MP)

12:00 p.m. Luncheon: Council & Past Presidents (Monarch-MP)

12:15 p.m. Scientific Luncheons* followed by afternoon programs (MECCA)

NOTE: NO TICKET SALES AFTER APRIL 8.

Friday Plenary Sessions

Panel on RASHES

(Room E-2)

9 a.m. to 10:20 a.m.

This program is accredited through the State Medical Society of Wisconsin for 1½ hours of Category I credit of the PRA and 1½ hours of prescribed American Academy of Family Physicians credit (AAFP).

NOTE: This panel will be repeated on Saturday 9 a.m. to 10:20 a.m.

Moderator: William E. Hein, MD, Green Bay

Section on Allergy & Clinical Immunology

(Friday) S. Roger Hirsch, MD, Milwaukee

(Saturday) John S. Hyde, MD, Professor of Pediatrics, Presbyterian-St. Luke's Hospital, Chicago

Section on Dermatology

Robert W. Goltz, MD, Professor & Head, Dept. of Dermatology, University of Minnesota

Section on Pediatrics

Thomas V. Geppert, MD, Madison

Panel on VENEREAL HERPES

(Room E-5)

9 a.m. to 10:20 a.m.

This program is accredited through the State Medical Society of Wisconsin for 1½ hours of Category I credit of the PRA and 1½ hours of prescribed American Academy of Family Physicians credit (AAFP).

Moderator: Donn J. D'Alessio, MD, Madison

Presented jointly by Sections on Internal Medicine and Public Health & Preventive Medicine

Andre J. Nahmias, MD, Professor & Chief, Infectious Disease & Immunology Division, Emory University School of Medicine, Atlanta, Georgia

10:20 a.m. Recess to View Exhibits (Coffee avail.)

Panel on IMPOTENCE

(Room E-2)

10:40 a.m. to 12:00 noon

This program is accredited through the State Medical Society of Wisconsin for 1½ hours of Category I credit of the PRA and 1½ hours of prescribed American Academy of Family Physicians credit (AAFP).

NOTE: This panel will be repeated on Saturday 9 a.m. to 10:20 a.m.

Moderator: John B. Wear, MD, Madison

Section on Psychiatry

James W. Jefferson, MD, Madison

Section on Urology

Ralph C. Benson, MD, Madison

Section on Obstetrics & Gynecology

John B. Nettles, MD, Professor & Chairman, University of Oklahoma Tulsa Medical College

Panel on PRACTICAL NEURO-OPHTHALMOLOGY: RADIOLOGICAL AND CLINICAL APPROACHES

(Room E-5)

10:40 a.m. to 12:00 noon

This program is accredited through the State Medical Society of Wisconsin for 1½ hours of Category 1 credit of the PRA and 1½ hours of prescribed American Academy of Family Physicians credit (AAFP).

Section on Ophthalmology

Walter Gager, MD, Medical College of Wisconsin, Milwaukee

Section on Radiology

Katherine A. Shaffer, MD, Alan L. Williams, MD, Medical College of Wisconsin, Milwaukee

12:15 p.m. Socio-economic Luncheon

Speaker: Dr. Walter McClure, Director Health Policy & Planning INTERSTUDY, Excelsior, MN.

(W. Hall - MECCA - 1st Floor)

MEDICINE AND RELIGION BREAKFAST

James Land, MD, Madison, Wis. - **Sequels to Success** *(Friday, April 15,* 7:15 a.m., Marc Plaza, Regency Room)
[Cosponsored by the SMS Committee on Medicine and Religion and the Catholic Physicians Guild]

Panel on BREAST CARCINOMA

(Room E-2)

1:45 p.m. to 4:45 p.m.

This program is accredited through the State Medical Society of Wisconsin for 3 hours of Category I credit of the PRA and 3 hours of prescribed American Academy of Family Physicians credit (AAFP).

Moderator: Marcia J. S. Richards, MD, Radiation Oncologist, St. Mary's Hospital, Milwaukee

1:45 p.m. *"Breast Screening, Current Status"*
John R. Milbrath, MD, Director, Breast Cancer Detection Center, Medical College of Wisconsin, Milwaukee

2:00 p.m. *"Management of Abnormalities Discovered During Screening"*
J. David Lewis, MD, Associate Professor of Surgery, Medical College of Wisconsin, Milwaukee

2:15 p.m. *"Surgical Alternatives in the Management of Breast Cancer"*
William L. Donegan, MD, Professor of Surgery, Medical College of Wisconsin; Oncological Professorship, American Cancer Society

2:45 p.m. Recess to View Exhibits (Coffee avail.)

3:00 p.m. *"Radiation Therapy in Early Breast Cancer"*
Peter Fitzpatrick, MD, Assistant Professor of Therapeutic Radiology, Princess Margaret Hospital, Ontario Cancer Institute, Ontario, Canada

3:30 p.m. *"The Role of Chemotherapy in Carcinoma of the Breast"*
Paul P. Carbone, MD, Director, Division of Clinical Oncology, Professor of Human Oncology & Medicine, UW Medical School, Madison

4:00 p.m. PANEL
Moderator: Marcia J. S. Richards, MD;
Panelists: Peter Fitzpatrick, MD, J. David Lewis, MD, William L. Donegan, MD, Paul P. Carbone, MD, John R. Milbrath, MD

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Panel on SPINAL INJURY

(Room E-5)

3 p.m. to 4:20 p.m.

This program is accredited through the State Medical Society of Wisconsin for 1½ hours of Category I credit of the PRA and 1½ hours of prescribed American Academy of Family Physicians credit (AAFP).

NOTE: This panel will be repeated on Saturday 10:40 a.m. to 12:00 noon

Moderator: Thomas J. Flatley, MD, Milwaukee

Section on Neurology
Kenneth M. Viste, MD, Oshkosh

Neurosurgery
William F. Meacham, MD, Chief of Neurosurgery, Vanderbilt University Medical School, Nashville, Tenn.

Section on Orthopedics
David S. Bradford, MD, Department of Orthopedic Surgery, University of Minnesota, Minneapolis

Section on Physical Medicine & Rehabilitation
Joel S. Rosen, MD, Co-Director, Midwest Regional Spinal Cord Injury Center, Chicago

Saturday Plenary Sessions

Panel on RASHES
(Room E-2)
9 a.m. to 10:20 a.m.
This is a repeat of the Friday program!
Moderator: Thomas V. Geppert, MD, Madison

Panel on IMPOTENCE
(Room E-5)
9 a.m. to 10:20 a.m.
This is a repeat of the Friday program!
Moderator: John B. Wear, MD, Madison
10:20 a.m. Recess to View Exhibits (Coffee avail.)

Panel on CHOICE OF ANESTHESIA TECHNIQUE
(Room E-2)
10:40 a.m. to 12:00 noon
This program is accredited through the State Medical Society of Wisconsin for 1½ hours of Category I credit of the PRA and 1½ hours of prescribed American Academy of Family Physicians credit (AAFP).
Moderator: John P. Kampine, MD, Brookfield
Section on Anesthesiology
Robert E. Holzgrafe, MD, Milwaukee
Maxwell Weingarten, MD, Milwaukee
Section on Obstetrics & Gynecology
John B. Nettles, MD, Professor & Chairman
University of Oklahoma Tulsa Medical College
Harold I. Borkowf, MD, Milwaukee

Panel on SPINAL INJURY
(Room E-5)
10:40 a.m. to 12:00 noon
This is a repeat of the Friday program!
Moderator: Glenn A. Meyer, MD, Milwaukee

Saturday Luncheons

All luncheons held on Saturday, April 16, at MECCA unless otherwise noted.

12:15 p.m. Allergy & Clinical Immunology (Rm E-10)
Anesthesiology (Rm W-2)
Dermatology (Fri., Apr. 15, Rm E-3)
Internal Medicine (Rm W-3)
Neurology (Rm W-9)
Obstetrics & Gynecology (Rm W-4)
Ophthalmology (Thurs., Apr. 14, Rm E-3)
Orthopedics (Rm E-4)
Otolaryngology (Rms E-14 & 15)
Pathology (Rm W-10)
Pediatrics (RM E-7)
Plastic Surgery (Rm E-3)
Physical Medicine & Rehabilitation (Fri., Apr. 15, Maders Restaurant, downtown Milwaukee at 12:00 noon)
Public Health & Preventive Medicine (Members will join Section on Internal Medicine, Rm W-3)
Radiation Oncology (Fri., Apr. 15, Rm W-10)
Radiology (Rm W-5)
Surgery (Milwaukee Children's Hospital, See complete schedule elsewhere in this section)

BEAUMONT MEMORIAL LECTURE
Robert Zeppa, MD, FACA, Miami, Fla. - **Portal Hypertension,** *(Saturday, April 16,* 2:15 p.m. Surgery Program/MECCA)

ELVEHJEM MEMORIAL LECTURE
Andre J. Nahmias, MD, Atlanta, Ga. - **Herpes Virus: Epidemiology, Genital Lesions, Relation to Cancer - Diagnosis and Treatment of Herpes Infection,** *(Saturday, April 16,* 3:20 p.m. Internal Medicine Program/MECCA)

Scientific Programs

All programs on Saturday at MECCA unless otherwise indicated.

Allergy & Clinical Immunology

(Room W-3)

This program is accredited through the State Medical Society of Wisconsin and the Wisconsin Allergy Society for 2½ hours of Category I credit of the PRA.

Moderator: S. Roger Hirsch, MD, Milwaukee; President, Wisconsin Allergy Society

12:15 p.m. Luncheon

"Management of Chronic Asthma"

John S. Hyde, MD, Professor of Pediatrics Presbyterian-St. Luke's Hospital, Chicago, Illinois

2:00 p.m. *"Heterozygous Alpha$_1$ Antitrypsin and Lung Disease"*

John S. Hyde, MD

3:00 p.m. **Recess to View Exhibits (Coffee avail.)**

3:15 p.m. *"Hyposensitization for Bee Stings: Use of Venom Extract"*

Sheldon Forman, MD, Milwaukee

3:30 p.m. *"Thyroid Disease and Asthma"*

Robert K. Bush, MD, Madison

3:45 p.m. Business Meeting: Wisconsin Allergy Society

Adjournment

Anesthesiology (Room W-2)

Moderator: Rudy P. Froeschle, MD, Waukesha

12:15 p.m. Luncheon

"Can You Teach an Old Dog New Tricks?"

Alon P. Winnie, MD, Professor & Chairman Department of Anesthesiology, University of Illinois Medical Center, Chicago

2:00 p.m. *"Anticholingergic Agents: A Second Look"*

Alon P. Winnie, MD

3:00 p.m. **Recess to View Exhibits (Coffee avail.)**

3:15 p.m. *"Anesthetic Considerations in the Hypertensive Patient"*

John P. Kampine, MD, Milwaukee

4:00 p.m. Business Meeting: Section on Anesthesiology and Wisconsin Society of Anesthesiologists

Adjournment

Dermatology (Room E-3) *(Fri., April 15)*

This program is accredited through the State Medical Society of Wisconsin and the Wisconsin Dermatological Society for 3½ hours of Category I credit of the PRA.

12:15 p.m. Luncheon

Presentation by guest speaker Robert W. Goltz, MD, Professor & Head, Dept. of Dermatology, University of Minnesota, Minneapolis

Moderator: Derek J. Cripps, MD, Madison

1:45 p.m. *"Current Knowledge of Connective Tissue"*

Robert W. Goltz, MD

3:00 p.m. *"Recurrent Aphthous Stomatitis ('Canker Sores')"*

R. S. Rogers III, MD, Assistant Professor of Dermatology, Mayo Clinic, Rochester

"Photochemotherapy for Psoriasis"

Derek J. Cripps, MD

"Chemosurgery for Skin Cancer: Fixed Tissue and Fresh Tissue Techniques"

Frederic E. Mohs, MD, Madison

"What's New in Dermatology Therapy"

Norman F. Deffner, MD, Wausau

"Sexually Transmitted Diseases 1977"

Stephen B. Webster, MD, La Crosse

5:00 p.m. Adjournment

SOCIO-ECONOMIC LUNCHEON

Friday, April 15 - 12:15 p.m.

MECCA - W. Hall - 1st Floor

Speaker -

Dr. Walter McClure

Director, Health Policy & Planning, INTERSTUDY, Excelsior, MN.

Internal Medicine (Room E-10)

(Sponsored by the Wisconsin Society of Internal Medicine & American College of Physicians)

12:15 p.m. Luncheon

"Herpes Virus and Cancer"

Andre J. Nahmias, MD, Professor and Chief, Infectious Disease and Immunology Division, Emory University School of Medicine, Atlanta, Georgia

Moderator: B. J. Haza, MD, Appleton; President, Wisconsin Society of Internal Medicine

2:00 p.m. *"Infectious Mononucleosis - Diagnosis and Treatment with Steroids"*

Michael P. Mehr, MD, Marshfield

2:20 p.m. *"Viral Etiology of Neuromuscular Disease with Particular Emphasis on Measles Virus in Association with Multiple Sclerosis"*

Burton A. Waisbren, MD, Milwaukee

3:05 p.m. Recess to View Exhibits (Coffee avail.)

3:20 p.m. ELVEHJEM MEMORIAL LECTURE

"Herpes Virus: Epidemiology, Genital Lesions, Relation to Cancer - Diagnosis and Treatment of Herpes Infection"

Andre J. Nahmias, MD

4:05 p.m. PANEL: Questions & Answers

Andre J. Nahmias, MD, Michael P. Mehr, MD, Burton A. Waisbren, MD

Adjournment

4:30 p.m. Meeting: Council & General Membership, Wisconsin Society of Internal Medicine

Milwaukee Athletic Club

6:00 p.m. Evening Dinner Meeting - Milwaukee Athletic Club

Contact Don McNeil (414-276-6445) for tickets.

Neurology

This program is accredited through the State Medical Society of Wisconsin and the Wisconsin Neurological Society for 2½ hours of Category I credit of the PRA.

12:15 p.m. Luncheon (Room W-9)

"On the Care and Feeding of National Commissions"

Cornelius L. Hopper, MD, Vice President for Medical Affairs, Tuskegee Institute, Alabama

Moderator: Gamber F. Tegtmeyer, MD, Madison

(Room W-8)

2:00 p.m. *"A New Method for the Study of Cerebrospinal Fluid Spaces & Pathways"*

Joseph F. Sackett, MD, Madison

2:30 p.m. *"Normal & Pathologic Computerized Anatomy of the Brain"*

Charles M. Strother, MD, Madison

3:00 p.m. Recess to View Exhibits (Coffee Avail.)

3:15 p.m. *"The Rural Health System & the Epileptic: A Study"*

Cornelius L. Hopper, MD

3:45 p.m. *"Advances in Diagnosis & Treatment of Parkinsonism & Other Selected Movement Disorders"*

Phillip M. Green, MD, Marshfield

4:05 p.m. *"Diagnosis & Treatment of Transient Ischemic Attacks"*

Phiroze M. Hansotia, MD, Marshfield

4:25 p.m. Business Meeting - Section on Neurology

Gamber F. Tegtmeyer, MD, Chairman, Madison

Adjournment

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Obstetrics & Gynecology

(Room W-4)

12:15 p.m. Luncheon (Tickets Back Cover)

Moderator: Frederick J. Hofmeister, MD, Milwaukee

"Controversial Issues in Obstetrics & Gynecology"

John B. Nettles, MD, Professor & Chairman, University of Oklahoma Tulsa Medical College

Moderator: William J. O'Leary, MD, LaCrosse

1:45 p.m. *MOVIE: "Total Recto-Vaginal Reconstruction Utilizing the Gracilis Muscle Slings"*

David G. Dibbell, MD, Madison

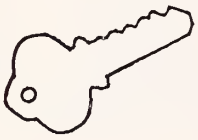
2:15 p.m. *"The Obstetrician & Gynecologist in the Pediatric Clinic"*

Walter R. Schwartz, MD, Milwaukee

2:45 p.m. *"Practical Aspects in the Office Diagnosis and Management of Vulvar Lesions"*

Eduard G. Friedrich, MD, Milwaukee

Adjournment



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Ophthalmology (Room E-3) *(Thurs., April 14)*

This program is accredited through the State Medical Society of Wisconsin and its Section on Ophthalmology for 1½ hours of Category I credit of the PRA.

12:15 p.m. Luncheon

Business Meeting: Section on Ophthalmology

Chairman: Donald E. Chisholm, MD, Milwaukee

Scientific Program Moderator: Richard O. Schultz, MD, Milwaukee

1:30 p.m. *"Retinal Vascularization, Collaterals and Shunts: the Importance of their Clinical Recognition"*

Paul Henkind, MD, Ph.D., Professor & Chairman, Department of Ophthalmology, Albert Einstein College of Medicine, New York City

3:00 p.m. Adjournment

Orthopedics (Room E-4)

This program is accredited through the State Medical Society of Wisconsin and the Wisconsin Orthopaedic Society for 2½ hours Category I credit of the PRA.

12:15 p.m. Luncheon

Moderator: James M. Huffer, MD, Madison

2:00 p.m. *"Internal Fixation of Fracture Dislocations of the Lumbar Spine"*

Sam P. Nesemann, MD, Milwaukee

2:20 p.m. *"Reconstruction Tendon Transfers for Upper Extremities in Quadriplegics"*

Thomas J. Flatley, MD, Milwaukee

2:55 p.m. *"Skeletal Traction Treatment of Comminuted Distal Radial Fractures"*

Jeffrey C. Thomas, MD, Janesville

3:15 p.m. Recess to View Exhibits (Coffee avail.)

3:30 p.m. *"Surgical Treatment for Comminuted Fractures of the Femur"*

Richard L. Buechel, MD, Wausau

3:50 p.m. *"Soft Tissue Coverage Problems in the Lower Extremity"*

Stephen P. Bloch, MD, Madison

4:10 p.m. *"Treatment of Ankle Fractures by Crossed Screw Fixation Through Syndesmosis"*

Harvey L. Barash, MD, Madison

4:30 p.m. Business Meeting

Adjournment

6:00 p.m. Evening Dinner: Wisconsin Orthopaedic Society (by invitation)

Otolaryngology

This program is accredited through the State Medical Society of Wisconsin and the Wisconsin Otolaryngological Society for 4 hours of Category I credit of the PRA.

9:00 - 11:15 a.m. Wet Clinic, Veterans Administration Center, Wood, WI.

12:15 p.m. Luncheon (MECCA) **(Rooms E-14 & 15)**

Moderator: John E. Clemons, MD, La Crosse, President, Wisconsin Otolaryngological Society

(Room E-13)

1:30 p.m. *"Head and Neck Cancer Surgery, Cure and Rehabilitation"*
Donald B. Shumrick, MD, Professor & Chairman, Dept. of Otolaryngology and Maxillofacial Surgery, University of Cincinnati Medical Center

2:15 p.m. *"Actinomycosis of Larynx: A Case Report and Review of the Literature"*
Wayne R. Kirkham, MD, Senior Resident in Otolaryngology, UW Medical School

2:30 p.m. *"Hemifacial Spasm: Microsurgical Vascular Decompression"*
Byron Annis, MD, La Crosse

3:00 p.m. **Recess to View Exhibits** **(Coffee avail.)**

3:15 p.m. *"Post-irradiation Changes for Benign Disease: An ENT Survey"*
Harvey Kleiner, MD, Senior Resident in Otolaryngology, Medical College of Wisconsin

3:25 p.m. Business Meeting: Wisconsin Otolaryngological Society

Adjournment

Pathology

This program is accredited through the State Medical Society of Wisconsin and the Wisconsin Society of Pathologists for 5 hours of Category I credit of the PRA.

9:30 a.m. Registration (coffee & rolls)

(Room E-6)

10:00 a.m. *"Classification of Soft Tissue Tumors"*
Juan Rosai, MD, Professor of Laboratory Medicine & Pathology; Director of Anatomical Pathology, University of Minnesota Medical School, Minneapolis

12:00 noon Adjournment

12:15 p.m. Luncheon **(Room W-10)**

1:15 p.m. Business Meeting: Section on Pathology

(Room E-5)

2:00 p.m. *"Slide Seminar on Soft Tissue Tumors"*
Juan Rosai, MD

5:00 p.m. Adjournment

Evening Dinner Meeting

Pediatrics

12:15 p.m. Luncheon **(Room E-7)**

"Modern Approach to Disturbance of Immunity"
Richard Hong, MD, Madison

(Room E-8)

1:45 p.m. *"Hematuria in Children"*
William E. Segar, MD, Madison

2:45 p.m. **Recess to View Exhibits** **(Coffee avail.)**

3:00 p.m. *"Recent Advances in Childhood Cancer"*
Paul F. Dvorak, MD, Madison

4:00 p.m. *"Recent Advances in Therapy of Faults of the Immune System: Re-tooling Mother Nature's Assembly"*
Richard Hong, MD, Madison

5:00 p.m. Adjournment

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Plastic Surgery (Room W-6)

This program is accredited through the State Medical Society of Wisconsin and the Wisconsin Society of Plastic Surgeons for 6 hours of Category I credit of the PRA.

9:00 a.m. *PANEL: "Correction of Drooling - Cerebral Palsy"*

Moderator: Harold J. Hoops, MD, Green Bay
Plastic Surgery: Wilbert Wiviott, MD, Milwaukee
Ear, Nose & Throat: Jerry Friedman, MD, Milwaukee
Speech Pathology: Joan Rechner Olson, MS, Milwaukee

9:40 a.m. *FILM: "Use of the Vomer Flap in Cleft Palate"*
Sidney K. Wynn, MD, Milwaukee

9:55 a.m. *"Axillary Approach to Augmentation Mammoplasty"*
Ralph A. Kloehn, MD, Milwaukee

10:10 a.m. **Recess to View Exhibits** (Coffee avail.)

10:20 a.m. *"Microsurgical Techniques in Plastic Surgery"*
Sherman G. Souther, MD, Madison

10:35 a.m. *"Complex Syndactylia"*
William H. Frackelton, MD, Milwaukee

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11:00 a.m. *"Breast Reconstruction Following Mastectomy"*
John E. Woods, MD, Head, Section of Plastic Surgery, Mayo Clinic, Rochester

12:00 noon Adjournment

12:15 p.m. Luncheon (Room E-3)

1:00 p.m. **RESIDENTS' HOUR** (Room E-3)
"Unusual Aspects of Velopharyngeal Function in Musicians"
William L. Carter, MD, Madison; Discussant, Sidney K. Wynn, MD
FILM: "Rectovaginal Reconstruction"
David R. Finch, MD, Madison; Discussant, Eugene A. Schrang, MD, Neenah

2:00 p.m. *"Total Wrist Replacement in Rheumatoid Arthritis"*
Donald M. Levy, MD, Milwaukee

2:15 p.m. *PANEL: "Treatment of Skin Cancer"*

Moderator: Frank D. Bernard, DDS, MD, Madison
Chemosurgery: "Mohs' Technique", Daniel L. Jones, MD, Eau Claire
Plastic Surgery: Jerome J. Luy, MD, Grafton
Radiology: David Harter, MD, Milwaukee

3:00 p.m. **Recess to View Exhibits** (Coffee avail.)

3:15 p.m. *"Massive Surgery"*
David G. Dibbell, MD, Madison

3:30 p.m. *"Early Mobilization After Hand Fractures"*
Ruedi P. Gingrass, MD, Milwaukee

3:45 p.m. Business Meeting

6:00 p.m. Dinner Meeting - University Club

Physical Medicine & Rehabilitation

(Fri., April 15)

12:00 noon Luncheon and Meeting
Maders Restaurant, downtown Milwaukee
Speaker: Joel Rosen, MD, Chicago
Tickets may be obtained by contacting Walter L. Modaff, MD, PM&R Dept. St. Francis Hospital (414-647-5246)

Public Health & Preventive Medicine

(Room W-14)

Note: Members will join the Section on Internal Medicine at its luncheon at 12:15 p.m.

2:00 p.m. Business Meeting
Adjournment

Radiation Oncology

(Room W-10) *(Fri., April 15)*

This program is accredited through the State Medical Society of Wisconsin and the Wisconsin Society of Radiation Oncologists for 1 hour of Category I credit of the PRA.

12:15 p.m. Luncheon

Moderator: Marcia J. S. Richards, MD, Milwaukee

12:45 p.m. *"The Philosophy of Radiotherapy"*
Peter Fitzpatrick, MD, Assistant Professor of Therapeutic Radiology, Princess Margaret Hospital, Ontario Cancer Institute, Ontario, Canada

2:00 p.m. Adjournment

Radiology
Computerized Tomography

MORNING SESSION

(Room E-11)

9:45 a.m. *"Anatomic and Pathologic Correlations with Cranial Computerized Tomography"*
Charles M. Strother, MD, Madison

10:05 a.m. *"Evaluation of Head Trauma with Cranial Computerized Tomography"*
A. L. Williams, MD, Milwaukee

10:25 a.m. *"The Stroke Syndrome and Its Evaluation with Cranial Computerized Tomography"*
Edgar L. Koch, MD, Marshfield

10:45 a.m. *"CNS Neoplasms - Initial and Follow-up Findings with Cranial Computerized Tomography"*
Joseph F. Sackett, MD, Madison

11:05 a.m. Panel Discussion

Moderators: Andrew B. Crummy, MD, Madison, Marvin L. Hinke, MD, Marshfield

Panelists: Edgar L. Koch, MD, Marshfield Charles M. Strother, MD, Joseph F. Sackett, MD, Madison

11:30 a.m. Adjournment

AFTERNOON SESSION

12:15 p.m. Luncheon (Room W-5)

1:00 p.m. Business Meeting: Wisconsin Radiological Society

2:00 p.m. *"Computerized Axial Tomography of the Retroperitoneum and Pancreas"*
Patrick F. Sheedy, MD, Radiologist, Mayo Clinic, Rochester

2:20 p.m. *"Computerized Axial Tomography of the Kidney"*
Robert Koehler, MD, Assistant Professor of Radiology, Washington University, St. Louis

2:45 p.m. *"Computerized Axial Tomography in Musculoskeletal Disorders"*
Patrick F. Sheedy, MD

3:05 p.m. *"Computerized Axial Tomography of the Liver and Biliary Tree"*
Robert Koehler, MD

3:25 p.m. Panel Discussion

Moderators: Andrew B. Crummy, MD, Madison; Marvin L. Hinke, MD, Marshfield

Panelists: Robert Koehler, MD, St. Louis, MO.; Patrick Sheedy, MD, Rochester, MN.

3:45 p.m. Adjournment

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Surgery

This program is accredited through the State Medical Society of Wisconsin and the Wisconsin Surgical Society for 7½ hours of Category I credit of the PRA.

MORNING SESSION
Milwaukee Children's Hospital

8:00 a.m. to 12 noon Wet Clinic (& luncheon)
Chairman: Marvin Glicklich, MD, Milwaukee

AFTERNOON SESSION
MECCA **(Room E-2)**
Chairman: J. David Lewis, MD, Milwaukee

1:30 p.m. *"Upper Gastrointestinal Endoscopy and the Surgeon"*
James H. Woods, MD, Elm Grove

1:40 p.m. Discussion

1:45 p.m. *"Gastric Autoantibody and Serum Gastrin in Achlorhydric States"*
Luther M. Keith, MD, Dept. of Surgery, Ohio State University, Columbus
William D. Turnipseed, MD, Madison

1:55 p.m. Discussion

2:00 p.m. *"Jejunal Diverticulosis"*
William A. Kisken, MD, La Crosse

2:10 p.m. Discussion

2:15 p.m. **WILLIAM BEAUMONT LECTURE**
"Portal Hypertension"
Robert Zeppa, MD, FACS, Professor & Chairman, Department of Surgery, University of Miami

3:00 p.m. **Recess to View Exhibits** **(Coffee avail.)**

3:15 p.m. *"Current Diagnosis and Surgical Management of Cerebrovascular Disease"*
Fredric Jarrett, MD, Madison

3:25 p.m. Discussion

3:30 p.m. *"Revascularization of the Ischemic Kidney"*
Jonathan B. Towne, MD, Brookfield
Victor M. Bernhard, MD, Milwaukee

3:40 p.m. Discussion

3:45 p.m. *"Intraaortic Balloon Pumping During Non-Cardiac Surgery"*
Lawrence I. Bonchek, MD, Leonard W. Worman, MD, Gordon N. Olinger, MD, Milwaukee

3:55 p.m. Discussion

4:00 p.m. *"Skin Grafting of Infected Pilonidal Disease" (FILM)*
Thomas J. Foley, MD, Milwaukee;
Albert G. Schutte, MD, Mukwonago

4:30 p.m. *Presidential Address: "Look Both Ways"*
P. Richard Sholl, MD, Janesville

5:00 p.m. Business Meeting

6:30 p.m. Dinner Meeting - Wisconsin Surgical Society (by invitation)
Milwaukee Athletic Club

EXHIBITS

Second Floor Convention Center
Exhibit Hours: 8 a.m. - 5 p.m., April 15-16

Scientific

(Sponsoring institution(s) followed by title of exhibit(s)

American Association of Hand Surgery
Examination of the Acutely Injured Hand

Bellin Memorial Hospital, Wisconsin Heart Institute, Green Bay
Somebody's Missing. The Surgical Treatment of Coronary Atherosclerosis in a Regional Hospital Environment

Columbia Hospital, Milwaukee (Dept. of Radiology)
CT Body Scanning
Transfer Factor
Coagulopathy - A Cause of Dysfunctional Bleeding in the Female

Gundersen Clinic, Ltd., La Crosse
Asymptomatic Gonorrhea in Clinical Medicine

Medical College of Wisconsin, Milwaukee
Biomedical Communications - Serving You Better then Ever (Library, Medical College of Wisconsin, Milwaukee; Library, UW Center for Health Sciences, Madison)
Cardiopulmonary Resuscitation (The Institute of Trauma & Emergency Medicine)
Comparative Pathology of the Femoral Head in Hip Joint Disease (VA Administration Hospital, Dept. of Orthopedic Surgery, Wood)
Gas Myelography in the Management of Spinal Cord Disorders in Children (& Shriner's Hospital for Crippled Children, Chicago)

Milwaukee Children's Hospital, Milwaukee

Bilateral Osteotomy Cleft Palate Surgery (Cleft Palate Center)

Changing Concepts in Management of Acute Upper Airway Obstruction in Children

Tympanometry - an Objective Technique to Help in the Diagnosis of Hearing Loss and Middle Ear Disorders of Children (Dept. of Audiology)

St. Joseph's Hospital, Milwaukee

Presentation of an approach to continuing medical education for the medical practitioner, formatted on microfiche, highlighting self-testing modalities, coupled with a retrievable data base

St. Mary's Hospital, Milwaukee

Creatine Kinase Isoenzymes in the Diagnosis of Myocardial Necrosis and Non-Cardiac Disorders

Wisconsin Bureau of Social Security Disability, Madison

Medical Evaluation Criteria Under the Social Security Disability program

Wisconsin Physicians Political Action Committee (WISPAC), Madison

Wisconsin Professional Review Organization (WisPRO), Madison; Foundation for Medical Care Evaluation of Southeastern Wisconsin, Milwaukee

Wisconsin State Department of Health & Social Services, Milwaukee

Wisconsin Division of Health

UW Center for Health Sciences, Madison

Biplane Arteriography in Lower Extremity Ischemia (VA Administration Hospital)

Cancer Information Service (Wisconsin Clinical Cancer Center)

Dual Computerized Voice Response System (DUVO)

Renal Osteodystrophy: Pathophysiologic, Radiologic Correlation

Wisconsin Lions Eye Bank (Dept. of Ophthalmology)

Technical

Abbott Laboratories, North Chicago, ILL

AMEDD Personnel Procurement, Ft. Sheridan, ILL

Ames Company, Div. Miles Laboratories, Elkhart, IND

Ayerst Laboratories, New York, NY

Boehringer-Ingleheim Ltd., Elmsford, NY

Bristol Laboratories, Syracuse, NY

Burroughs Wellcome Company, Research Triangle, NC

Cooper Laboratories, Parsippany, NJ

Doctors Diagnostic Laboratories, Minneapolis, MN

Encyclopaedia Britannica, Chicago, ILL

Fisons Corporation, Bedford, MASS

Hoechst-Roussel Pharmaceuticals, Inc., Somerville, NJ

International Business Machines Corp Milwaukee, WI

International Medical Electronics Ltd., Kansas City, MO

Kremers-Urban Company, Milwaukee, WI

Lederle Laboratories, Pearl River, NY

Eli Lilly & Company, Indianapolis, IND

Marion Laboratories, Inc., Kansas City, MO

Mead Johnson Laboratories, Evansville, IND

The Medical Protective Company, Ft. Wayne, IND

Merck Sharp & Dohme, West Point, PA

Metpath, Milwaukee, WI

Monarch Life Insurance Company, Milwaukee, WI

Ortho Pharmaceutical Corporation, Raritan, NJ

Phone-A-Gram System, San Francisco, CA

Reed & Carnick Pharmaceuticals, Kenilworth, NJ

Roche Laboratories, Nutley, NJ

J. B. Roerig Div. - Pfizer, Chicago, ILL

Rowell Laboratories, Inc., Baudette, MN

W. B. Saunders Company, Philadelphia, PA

Searle Laboratories, Chicago, ILL

The Seefurth-McGiveran Corporation, Milwaukee, WI

Stuart Pharmaceuticals, Wilmington, DEL

E. R. Squibb & Sons, Inc., Princeton, NJ

Syntex Laboratories, Inc., Palo Alto, CA

US Air Force Procurement Division, Oak Park, ILL

US Navy Medical Recruiting, Milwaukee, WI

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Malignant Melanoma

ALTHOUGH malignant melanoma is generally regarded as a virulent and often fatal disease, it is potentially curable if detected early enough. There are few major cancers that have as hopeful a prognosis.

According to Dr Thomas B Fitzpatrick, Wigglesworth Professor and Chairman of the Department of Dermatology of Harvard Medical School, high-risk populations, high-risk sites, and high-risk lesions should be carefully checked for early evidence of melanoma.

The *high-risk population* includes those people who have skins that sunburn easily but do not tan or only tan slowly. *High-risk sites* are presently (1) the upper part of the back in males and females, (2) lower legs of females, (3) anterior trunk of males, and (4) upper extremities. However, altered styles of dress may change these high-risk sites. The *high-risk lesions* are (1) nevi whose color is variegated with a disorderly arrangement of brown, black, blue, or grey hues, (2) nevi which have irregular borders, often with a notch which gives it a bean-shape, and (3) nevi which have an irregular surface without normal skin markings.

Any change in a pre-existing mole or the development of a new mole in an adult should be examined carefully. Malignant melanoma should be suspected if there is any change in size, elevation, color, surface characteristics, surroundings, or sensation of a nevus.

There are three main types of melanoma. The *lentigo maligna melanoma* (Hutchinson's melanotic freckle) is found most frequently on the malar regions and temples of people in their seventies and grows very slowly. *Nodular melanoma* may occur anywhere on the skin, has a very rapid onset, and occurs at about 45 years of age. The most common type is the *superficial spreading melanoma* which can occur on any part of the body, spreads very rapidly, and appears most commonly at about 40 to 50 years of age.

There is a higher incidence of melanoma in congenital raised nevi, so these should be excised surgically if possible.

At a recent seminar, Doctor Fitzpatrick suggested that all patients should be instructed to look for suspicious areas as the detection of melanoma is not difficult, then alert the physician to the lesion for possible treatment.—DOROTHY BUCHANAN DAVIDSON, PHD, Science Writer, Wisconsin Clinical Cancer Center

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

Radiation and Thyroid Cancer

In January the CBS program *Sixty Minutes* described a recall program in Pittsburgh in which people who had received radiation treatment of the thymus as children were being contacted by doctors to see if they had developed cancer of the thyroid gland.

Between 1930 to 1960, many people received radiation of the tonsils, adenoids, and thymus, and also the face and back for the treatment of acne. At that time, radiation was the best medical treatment known for certain benign diseases of infancy and childhood. Although this practice has been discontinued for many years, the occurrence of x-ray-induced thyroid carcinoma has not declined. Radiation-induced thyroid abnormalities may develop for several decades after treatment.

Because this type of radiation therapy is no longer used, this form of carcinogenesis should disappear in time. But now the exposed group of patients requires surveillance in order to permit early detection and treatment if present.

The immature thyroid of children less than five years old is apparently especially sensitive to radiation. In determining risk, it is even more important to know if the thyroid gland was actually within the radiation field. It is difficult to say how much radiation is dangerous for both the dosage and the schedule of treatment varied widely.

Dr William Caldwell, Director of the Radiation Oncology Division of University Hospitals, Madison, recommends that anyone who received 50 rads or more of radiation to the area of the thyroid should have a complete physical examination with special attention to the thyroid region and a base-line thyroid scan using ^{131}I or ^{98m}Tc. If this is negative and no thyroid abnormalities or lymph node nodules are found, then the patient should have yearly checkups of the thyroid by physical examination only, but no more routine scans. If the thyroid was distant from the field of radiation and the estimated dose to the thyroid was less than 50 rads, there is no need for concern.

Usually thyroid cancer does not have an aggressive clinical course, so that proper medical care at an early stage should largely prevent a serious outcome.

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Doctor John R Cameron, Director of the Medical Physics Laboratories of the University of Wisconsin, Madison, 3321 Sterling Hall, Madison, Wisconsin 53706, stresses that even some diagnostic procedures can give relatively large radiation doses. His laboratory offers a mailed dosimetry service to check on diagnostic exposures. It is being used exclusively for monitoring mammography exposures all over the United States. —DOROTHY J BUCHANAN DAVIDSON, PHD, Science Writer, Wisconsin Clinical Cancer Center

Head and Neck Cancer Conferences, Apr-May

Head and Neck Cancer Regional Conferences will be held April 23 at the Howard Young Medical Center in Woodruff; April 27 at St Vincent's Hospital in Green Bay; and May 4 at the Memorial Union South in Madison. (This last location was erroneously stated as Madison General Hospital in the February issue.) In the morning, guidelines for the primary physician and dentist doing head and neck examinations and radiological and surgical treatment of head and neck cancers will be discussed. The afternoon will be devoted to workshops. A fiberoptic nasopharyngolaryngoscope will be displayed.

For reservations contact the Wisconsin Division of the American Cancer Society, Inc, 611 North Sherman Avenue, Madison, telephone 1-608-249-0487.

April Cancer Programs

The Annual Meeting of the State Medical Society and the meeting of the Southeastern Wisconsin Cancer Conference have programs of interest to oncologists in April. For details, see programs elsewhere in this issue. ■

NEWS HIGHLIGHTS

Whitehall Clinic Reopens

The Whitehall Clinic, Inc, recently leased the top floor of the building to Rural Health Group, Ltd, an affiliate of Mid-American Medical Services, Inc. The Group includes MDs C F Meyer,* Whitehall, general practice and surgery; John C Kirkpatrick,* general practice and radiation oncology; Karl E Walter,* general practice and surgery; and Alan W Babcock,* general practice and internal medicine, all from Madison. Doctor Meyer formerly had a practice in Independence, then went to Whitehall Packing Company. Doctor Kirkpatrick is president of the Rural Health Groups as well as president of Mid-American Medical Services, Inc. Doctor Walter has practiced medicine in Eau Claire and Doctor Babcock recently was certified by the American Board of Internal Medicine. Two physicians will staff the clinic each day.

Gundersen Clinic Ltd

. . . in LaCrosse recently elected new officers to its board of directors. They are: president—Kermit L Newcomer, MD,* Dept of Internal Medicine; executive vice-president—Sigurd B Gundersen Jr, MD,* Dept of Surgery; vice-president—Edward L Perry, MD,* Dept of Internal Medicine; and secretary-treasurer—William A Kisken, MD,* Dept of Surgery.

Other members of the Gundersen Clinic medical staff on the board of directors are: Adolf L Gundersen, MD,* Dept of Surgery; Cornelius A Natoli, MD,* Dept of Urology; J Michael Hartigan, MD,* Dept of Pediatrics; William A Morgan, MD,* Dept of Internal Medicine; and John D Swingle, MD,* Dept of Radiology.

UW-Madison

. . . Center for Health Sciences is presently planning a master's degree in Preventive Medicine for practicing clinicians with managerial or administrative responsibilities. MDs Don Detmer,* director of administrative medicine, and Jay Noren, associate director, report that in the area of administrative medicine there will be offered three tracks including medical education institutions, multi-specialty group practice, and primary care.

Curriculum options proposed for this degree are still under review by the University. The directors point out that one distinguishing feature of this program as it is now planned is that students should be able to complete their studies without a prolonged absence from clinical responsibilities.

To date there have been designed four courses taught by a multi-specialty faculty which are offered during the three-week summer inter-session. These new graduate courses are presently available to any qualified health professional: Clinical Administration in Health Care Systems (3 credits), Health Care Planning (2 cr), Health Care Evaluation (2 cr), and Management in Health Care (1 cr seminar).

Outlines for each of the summer courses are available from the UW-Madison Dept of Preventive Medicine, 504 Walnut Street, Madison 53706; 608/263-2880.

SE Wisconsin Chapter, WAFP

. . . recently installed Henry Goldberg, MD,* Milwaukee, as its president. He succeeds James Geigler, MD,* Milwaukee. Lief Erickson, MD,* Burlington, was elected president-elect. James Zellmer, MD, Milwaukee, was elected secretary and Thomas Cox, MD,* Milwaukee, treasurer.

Wisconsin Neurological Society

. . . will hold its Eighteenth Meeting at the Olympia Princess in Oconomowoc, Friday and Saturday, May 13-14. The meeting is open to all interested physicians and allied health personnel, and it is approved for Category I credit. Details of the program will appear in the April issue of WMJ.

Section on Ophthalmology

. . . of the SMS reports elsewhere in this issue the formation of Medical Eye Services of Wisconsin, Incorporated (MESWinc), a nonprofit corporation organized by practicing ophthalmologists in Wisconsin to promote professional prepaid eye health care. ■

PHYSICIAN BRIEFS

Robert H Rifleman, MD*

. . . Stevens Point, recently was appointed medical director of the Department of Emergency Medicine, St Michael's Hospital, Stevens Point. He formerly was in private practice in Stevens Point.

Paul Christianson, MD

. . . Black River Falls, recently became associated with the Krohn Clinic. He graduated in 1968 from Northwestern University Medical School, Evanston, Ill, and served his internship at Good Samaritan Hospital, Phoenix, Ariz. He spent four years of surgery residency at Illinois Central Hospital and two years of cardiothoracic surgery at St Luke's Medical Center, Chicago. Prior to joining the Clinic, he was in private practice and also was an assistant professor at Rush Medical College, Chicago.

Chanda Kapur, MD

. . . recently began her medical practice at the Plymouth Clinic. An internist, Doctor Kapur is from New Delhi, India, where she began her medical schooling in New Delhi and in Cashmir. Prior to locating in Plymouth, Doctor Kapur had been in a residency program in Flint, Mich.

Timothy Peterson, MD

. . . St Louis Park, Minn, will be joining the medical staff of the Frederic Clinic in August. Doctor Peterson is now serving his residency in St Louis Park, Minn, and will be joining MDs William Fischer,* Donald Schwab,* and David Kelsey in the Clinic. He is a graduate of the University of Wisconsin Medical School in Madison.

Daniel F Johnson, MD*

. . . Eau Claire, recently was elected chief of the medical staff at Luther Hospital. Other officers elected were MDs Peter H Ullrich,* vice-chief of staff; Richard P Linden,* secretary-treasurer; Daniel T Kincaid* and Robert M Lotz,* members at large of the executive committee. All physicians are from Eau Claire.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

John F Gwin, MD

. . . Hudson, recently became associated with the Hudson Clinic, SC, in the practice of pediatrics. Doctor Gwin graduated from the University of Wisconsin Medical School, Madison, and served his residency at Children's Mercy Hospital, Kansas City, Mo. Prior to joining the Clinic, Doctor Gwin was associated with Pediatric Associates, Inc, PS, Bellevue, Wash. He will be joining MDs Myron G Anderson;* EJ Diefenbach;* Rubin E Fermin;* and John H Kiernan* at the Clinic.

John J Tordoff, MD*

. . . Janesville, recently was reelected chief of medical staff of Mercy Hospital medical-dental staff. A surgeon, Docotr Tordoff has been on the medical staff since 1953. Other officers elected are MDs John F Holmes,* Milton Junction, president of the staff; Thomas S Sargeant, Janesville, president-elect; and Stephen C Werner,* Janesville, secretary-treasurer.

Robert H Greenlaw, MD*

. . . Marshfield Clinic radiation therapist, will head a group in planning a comprehensive approach to meeting the needs of cancer patients from a broad area of North Central Wisconsin and the Upper Peninsula of Michigan. This planning phase of a Community Cancer Center is being funded through a grant of $49,881 to the Marshfield Medical Foundation by the National Cancer Institute.

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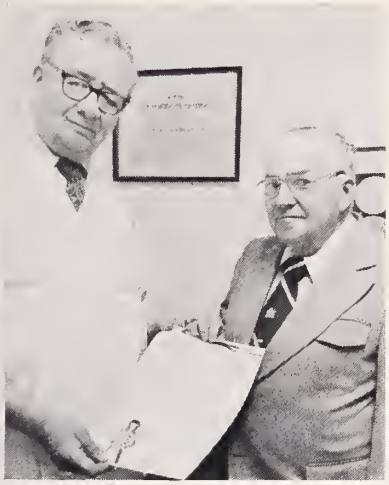
MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF FEBRUARY 1977

1 WisPro-FMCE Long Term Care Committee
1 Dane County Medical Society Board of Trustees
1 Dane County Medical Society Public Health Advisory Committee
3 Task Force on Health Screening and Immunization
4 WisPro-HSA Conference
4 SMS Committee on Evaluation of Delivery and Cost of Medical Care
4 SMS Commission on Continuing Medical Education
7 Dane County Medical Society Insurance Advisory Committee
7 Dane County HMP Committee
9 SMS Commission on Governmental Affairs
11 Study Committee on Maternal Mortality Survey
11 SMS Committee on Maternal and Child Health
11 Executive Committee of SMS Council
11 Ad Hoc Committee on Flu Immunization
16 SMS Commission on Health Facilities and Services
17 Board of Directors, Wisconsin Council of Professions
18 WisPro Nominating Committee
19 WPS Finance Committee
19 WPS Commission
19 WPS Claims Committee
21 Title 19 Provider Agreement Conference
22 State Advisory Council on Health Problems Education
23 SMS Committee on Rural Health
23 WisPro Executive Committee
24 Solid Tumor Group, Wisconsin Clinical Cancer Center
25 SMS Physicians Alliance Commission
25 SMS Committee on Medical Defense
28 Dane County HMP Committee

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parentheses.



Fred G Johnson, Jr, MD*
. . . Superior, (right) is shown receiving a special commendation by the State Medical Society of Wisconsin on the occasion of his retirement. Charles J Picard, MD* (left), president of the Society made the presentation. Doctor Johnson played a key role a few years ago in the dedication of a state historical marker on the site of the Evergreen Park Cottage Sanitorium, which was the first tuberculosis sanitorium in Wisconsin. (Evening Telegram Photo)

Jon F Franco, MD
. . . recently joined the medical staff of Superior Clinic, Ltd. Doctor Franco graduated from medical school in The Philippines and served his internship and residency training at St Peter's Hospital and Albany Medical Center, Albany, NY.

Herman C Schmallenberg, MD*
. . . New London, recently was reelected president of the New London Hospital medical staff. Also reelected are MDs Carlos C Yu,* vice-president; and Lloyd P Maasch,* secretary-treasurer, from New London.

Oliva Luib, MD
. . . Port Washington, recently joined the staff of the Grafton Medical Clinic. A graduate from Cebu College, Cebu, The Philippines, she served her internship at Lawrence Hospital, New York City, and her residency at Brookdale Hospital Center. Doctor Luib received fellowships in Clinical Pediatrics at Harlem Hospital, Neo-Natology at Methodist Hospital, New York City, and in Ambulatory Pediatrics at Kings County Hospital, New York. She also was a clinical instructor at Downstate Medical School, State University of New York.

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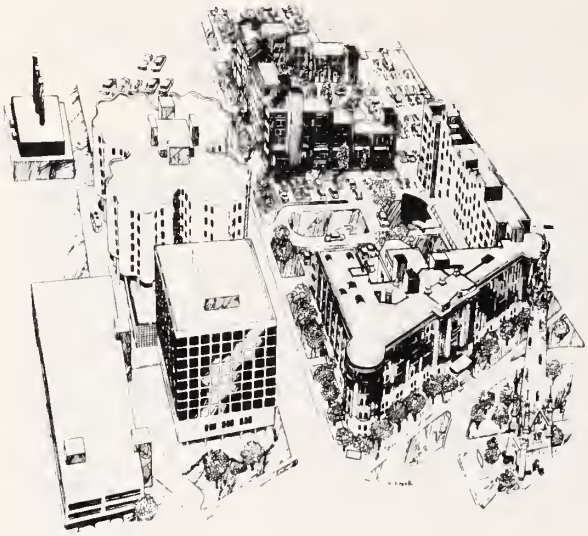

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Jack C Westman, MD*

. . . Madison, was elected president-elect of the American Association of Psychiatric Services for Children. He is professor of psychiatry at the University of Wisconsin-Madison.

Fred J Ansfield, MD*

. . . has terminated his affiliation with the University of Wisconsin-Madison and its Center for Health Sciences and has joined a group of practicing oncologists in Milwaukee.

George L Lucas, MD*

. . . Madison orthopedist, recently was elected vice president of the American Association for Hand Surgery.

Robert W Lightfoot Jr, MD

. . . has been appointed head of the Section of Rheumatology and associate professor in the Department of Medicine at the Medical College of Wisconsin, Milwaukee. ■

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INPATIENT, OUTPATIENT & DIAGNOSTIC SERVICES

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

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1155 Fifteenth Street, N.W., Washington, D.C. 20005

SECTION OPHTHALMOLOGY

MARCH 1977

EDITOR: Thomas M. Aaberg, MD, Milwaukee

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Diabetic Retinopathy Vitrectomy Study

The Diabetic Retinopathy Vitrectomy Study (DRVS), a new clinical trial, has recently begun enrollment. The purpose of this study is to determine the indications for pars plana vitrectomy in the treatment of severe proliferative diabetic retinopathy. Vitrectomy performed soon after severe hemorrhage in eyes with proliferative diabetic retinopathy will be compared with vitrectomy performed on eyes with long-standing hemorrhages, one year or longer.

Two groups of eyes are being studied, those with recent severe vitreous hemorrhage (H group) and those with severe neovascularization (N group) without severe vitreous hemorrhage.

To be eligible for the "H" group a patient must have in one or both eyes a severe vitreous hemorrhage, present for less than five months, which obscures the posterior fundus and impairs the visual acuity to less than 5/200. The patient should be seen as soon after onset of the hemorrhage as possible.

Eyes in this severely hemorrhaged group will be randomly assigned to either early or late vitrectomy. Those eyes with severe neovascularization will be followed without vitrectomy to gather information in order that a decision can be made regarding vitrectomy for this group in the future.

At the present time there are 13 clinical centers, a photograph reading center, and a coordinating center participating in this investigation. The Medical College of Wisconsin (Milwaukee) and the University of Wisconsin (Madison) are among these 13 centers.

If you have eligible patients or any questions please contact:

Mrs Sharon Rekow
The Medical College
of Wisconsin
Milwaukee, Wisconsin
414/257-5219

or

Mrs Diane Robbins
The University of
Wisconsin
Madison, Wisconsin
608/262-6393.

Wisconsin-Upper Michigan Society of Ophthalmology

Dr James C Allen, Madison, is retiring as secretary-treasurer of WUMSO after many years of unfailing duty to the Society. His leadership has allowed the Society to build in recent years. All Wisconsin-Upper Michigan ophthalmologists join in thanking him for his service.

Dr David Pfaffenbach, Manitowoc, succeeds Doctor Allen as secretary-treasurer. The splendid organization of this past year's meeting, under Doctor Pfaffenbach's direction, indicates the Society will continue to thrive under his leadership.

What Is MESWinc?

MESWinc is the Medical Eye Services of Wisconsin, Incorporated, and is a nonprofit corporation organized by practicing ophthalmologists in the State of Wisconsin to promote professional prepaid eye health care. MESWinc is endorsed by the American Association of Ophthalmology and supported by the Section on Ophthalmology of the State Medical Society of Wisconsin.

MESWinc has been organized to develop and sponsor prepaid medical eye service programs because of the growing public demand for ophthalmological care. Practically all present health programs exclude routine eye examinations for visual correction purposes and exclude the provision of optical material, such as glasses and contact lenses that are prescribed as a result of these examinations.

Such prepaid contractually funded programs have only just started to fill this void in recent years, and the demand is now accelerating. This demand is influenced by the increasing recognition of such programs serving both the interests of the employees and the employers. An equally significant influence is the fact that approximately 30 million people in the United States are already covered by some form of prepaid dental or prescription drug program, and they are now seeking medical eye service benefits.

The experience with these programs indicates that 95% of those covered by prepaid eye service programs go to the provider participants for their examinations. MESWinc has been organized to meet this in the State of Wisconsin and sponsor prepaid eye services programs on the following professional principles:

1. To preserve the role of the ophthalmologist as a primary point of entry into the health care delivery system for prepaid eye care.
2. It retains the fee-for-service principle of payment for medical services.
3. It preserves the principle of free choice of physician and protects the doctor-patient relationship.
4. It creates a physician-control organization to act as an intermediary between the providers

of medical eye care and the beneficiaries; namely, the patients.

5. It establishes an efficient physician-control organization ready to act as an intermediary between providers and patients in any national health insurance program that may be enacted.

MESWinc will organize open panels and supervise them in such a way as to reflect the interest of the practicing ophthalmologists and opticians within the State of Wisconsin. MESWinc will sponsor programs that will not place ophthalmologists or opticians at any risk. MESWinc is neither a health maintenance organization (HMO) nor an insurance company. MESWinc is designed for the ophthalmologist to retain any of his patients that might come under such programs and provide medical eye care for those who seek the services of an ophthalmologist. The most common medical service required by a patient is a comprehensive ophthalmological examination with diagnosis and initiation of treatment where necessary. Since 90% of the ophthalmologists in this state are general ophthalmologists, this is the most common medical service they provide. Refraction is an integral part of this medical examination, and this program covers such needs that are not covered in their usual health benefits.

Thirty-two other states in the United States already have developed a similar program and have become affiliated with the Medical Eye Services of America or are in the process of developing such an affiliate. On the national scene, General Motors, Chrysler, International Harvester, John Deere, and the Caterpillar corporations will probably provide eye services programs for their employees and dependents covered under the contract with UAW. The Ford Motor Company was included under a Vision Expense Benefits program with the UAW contract and will be eligible and covered under this program effective October 1, 1977.

These medical eye care programs, as organized in Wisconsin and other states, now will be able to provide panels and, in addition, professional peer review to any third party payer who wishes to provide eye services programs to its employees and beneficiaries.

MESWinc believes that the professional peer review program is important in providing high quality medical eye care and materials that go into spectacles and contact lenses. MESWinc is actively soliciting all the ophthalmologists in this state to join MESWinc and become a member of its participating panels. For any further information, please contact the doctors listed below.

At the time of the Ophthalmology Section meeting during the State Medical Society Annual Meeting, April 14-16, these doctors will be available to answer questions and give ophthalmologists further information regarding this program.

It is urgent that all ophthalmologists join MESWinc so that when the panels are published, all will be included. As of February 1, 1977 over 50 ophthalmologists have joined MESWinc. Join us and be a charter member. We need you and you need us.

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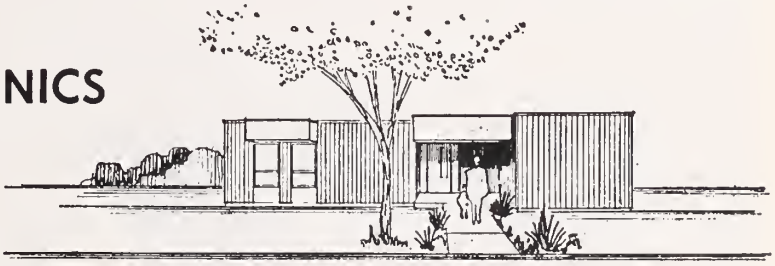

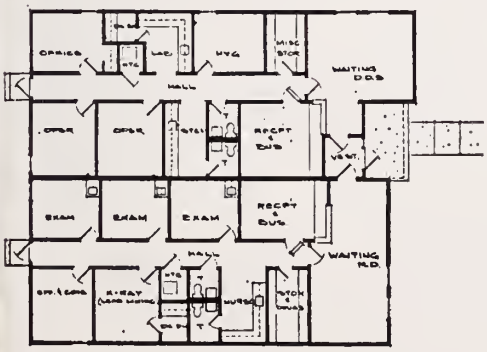

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report

for Wisconsin Physicians

Volume VI, Number 2 March 1977

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At WPS, we continually monitor the claims processing cycle to inform our management and supervisory staff of needed adjustments to meet performance standards.

During the fourth quarter of 1976, a number of claims submitted to WPS were sampled and the difference between the last date of service and the date on the claim (the date on which the claim began in the claims processing cycle at WPS) was computed. We are reporting the results so that you are better informed about the complexities of claims processing. These complexities occur throughout all facets of the health care delivery system from subscriber to provider to third-party payers.

For surgical-medical claims, an average of 37.6 days elapsed between the last date of service and the date affixed at WPS. For this category of claims, 41.8 percent arrived more than 30 days later. For hospital inpatient claims, the average span of time was 27.9 days; for hospital outpatient, 41.6; for Medicare plus claims, 85.7 days; and for major illness claims, 72.7 days.

Any interpretation of these figures must take into account the standard monthly billing method used by most medical practices and the handling delays attributable to subscribers submitting Medicare plus and Major Medical claims.

The importance to the customer/subscriber of effective claims processing is obvious. We at WPS constantly review our procedures to help insure you and all WPS subscribers the highest quality claims processing performance record possible. But we need your help in constantly monitoring this procedure. For example, by encouraging your patients to submit claims as soon as possible and by examining the time standards of your business practice, as we examine our own time standards, you can help WPS reduce claims processing time lags. At WPS we value and encourage your input into the task of constantly striving to improve our claims processing performance.

For further information contact Wisconsin Physicians Service:

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Explanation of Benefits Form

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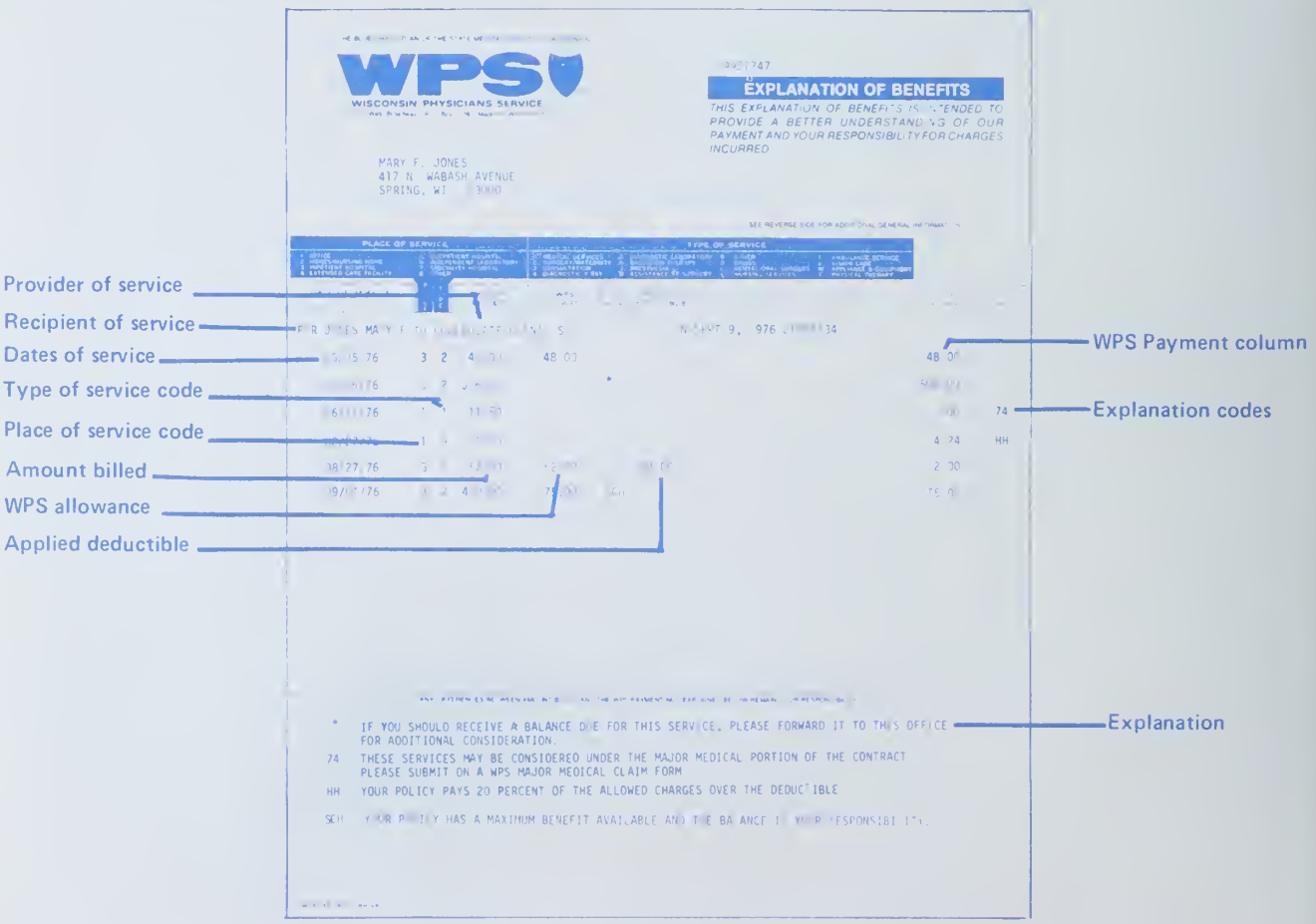
The EOB form describes to the subscriber the recipient and provider of the service, the place and type of service provided, the amount billed, any deductible applied, and the amount of the WPS payment. In those instances when no payment or only partial payment was made, symbols and number codes in the "See Below" columns alert the subscriber to explanations at the bottom of the form. It is important that the subscriber read the EOB form to determine the responsibility he has for the charges listed on it.

We are certain that this new form with its detailed explanations will be valuable to our subscribers.



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NEW PROFESSIONAL OFFICE for lease. Opportunity to plan and design your new office. Up to 2500 sq ft available on prestigious East Silver Spring Drive, Whitefish Bay area. Air conditioned, carpeted, ample parking. Available August 1977. For an appointment call Doctor Potter 414/332-3210 or 414/332-2233. 2tfn/77

OB-GYN, PEDIATRICS SPECIALists needed by 16-man multispecialty clinic in university community of 50,000 in Western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R Ujda, MD, LaCrosse Clinic, 212 South 11th St, LaCrosse, Wis 54601. 9-12/76,1-8/77

WI-FAMILY PRACTICE PHYSIcian wanted, incorporated clinic grp of 5, including family practice and general surgery. Ideal town in Northern Wis, 35 miles from Minneapolis. Income guaranteed 1st year. Contact J Craig, New Richmond Clinic, SC, New Richmond, Wis 54017. Tel: 715/246-2231. p11-12/76,1-4/77

ALLIED HEALTH SERVICES

1977 PHYSICIAN ASSISTANT graduate of the Johns Hopkins School of Health Services seeks employment in a primary care setting. Available July-August 1977. Professional credentials and other information available upon request. Write: P Rea Katz, 2529 Guilford Ave, Baltimore, MD 21218. p2-3/77

MEDICAL FACILITIES

OFFICE SPACE AVAILABLE: whole floor 3400 sq ft or part of floor for smaller office is desired. Will divide and remodel to your choice. Located in downtown Milwaukee, 174 West Wisconsin Ave. Convenient to all transportation and expressways. Parking garage in rear of building. Suitable for professional offices. Medical or dental laboratory facilities could be developed. Reasonable rent, long term lease if desired. Contact: Jay N Bhore, MD, 414/765-0225 or Patrick Meade, 414/276-1920. 7-12/76, 1-6/77.

FOR LEASE: OFFICE SPACE IN professional buildings adjacent to hospital existing and to be constructed. Specialists and general practitioners. Contact G P Williams, DDS, 1711 Shawano Ave, Green Bay, WI 54303; 1-414/494-9541. 2tfn/77

FOR SALE: MEDICAL BUILDING by owner. Reception room, file room, eight examining rooms, air conditioned, 18-car parking lot. Can accommodate up to four MDs. 8700 Racine Ave, Sturtevant, Wis 53177. Call collect Mr Robert C Cotter 414/886-4178. 3/77

OFFICE SPACE FOR RENT: Courtland Medical Center Building. Excellent location - 68th at West Capitol Drive, Milwaukee, Wis. Full lab and x-ray facilities available. Call 414/463-3704. 3/77*

OFFICE FOR RENT; 5232 W Oklahoma Ave, Milwaukee. Over 600 square feet. Three examination rooms, very large waiting room. Convenient location (bus stop at front door). Attractive low-rise building. Easy on-street and off-street parking. Available now. Tel: 414/476-4666. 12tfn/76

PROFESSIONAL LEASE SPACE AVAILABLE

Construction is completed on the new

OZAUKEE REHABILITATION CLINIC in Mequon. One block off the I-43 Expressway, the 12,000 sq ft professional building also houses an Outpatient Rehabilitation Agency. Lease areas available on ground or upper levels. Will divide or finish to your specifications. Immediate occupancy.

Also interested in a physician to become the Medical Director or Consultant to the Agency, which offers comprehensive clinical services including:

- Physical Therapy
- Speech Therapy
- Occupational Therapy
- Psychological Services
- Audiological Evaluations and Screening
- Aural Rehabilitation
- Impedance Testing
- Industrial Hearing Conservation

Contact Administrator
(414) 241-5530
1516 W Mequon Rd
Mequon, Wis 53092

CME Announcements

CONFERENCES FOR MEDICAL PROFESSIONALS.

Over 500 listings of national/international meetings, conferences and seminars in the medical sciences for 1977. Send a $10.00 check or money order payable to Professional Calendars, PO Box 40083, Washington, DC 20016. p1-6/77

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Health Care in a Changing Setting: The UK Experience. Ciba Foundation Symposium 43. CIBA Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1976. Pp 188.

Research and Medical Practice: Their Interaction. Ciba Foundation Symposium 44. CIBA Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1976. Pp 220.

Labor and Delivery: An Observer's Diary. By Constance A Bean. Publicity Department, Doubleday & Company, Inc, 245 Park Avenue, New York, NY 10017. 1977. Pp 202. Price: $6.95.

The Nurse Practitioner in an Adult Outpatient Clinic. U S Department of Health, Education, and Welfare, Public Health Service, Health Resources Administration, Bureau of Health Manpower, Division of Nursing, Bethesda, Maryland 20014. 1976. Pp 103.

Current Medical Diagnosis & Treatment. 16th Annual Revision. By Marcus A Krupp, MD and Milton J Chatton, MD. Lange Medical Publications, Drawer L, Los Altos, CA 94022. 1977. Pp 1066. Price: $16.00.

Innovation in the Pharmaceutical Industry. By David Schwartzman. The Johns Hopkins University Press, Baltimore, Md 21218. 1976. Pp 399. Price: $4.95. ■

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 9, 1976.

1977 WISCONSIN

Mar 31-Apr 2: Ophthalmology Current Concepts Seminar, UW Dept of Ophthalmology Faculty and Davis & Duehr Eye Clinic Staff, Madison. See details in box elsewhere in this issue.

Apr 2: Ninth Annual Southeastern Wisconsin Cancer Conference, Pfister Hotel, Milwaukee, Wis. See details in box elsewhere in this issue.

Apr 8-9: Notice of cancellation—The spring scientific meeting of the Wisconsin Psychiatric Association, scheduled for these dates, has been cancelled because of the conflict with the Good Friday/Easter weekend.

Apr 19-20: Patient Education in the Primary Care Setting, presented by University of Wisconsin Center for Health Sciences and Dept of Family Medicine and Practice with Dept of Continuing Medical Education, Health Sciences Unit, UW-Extension, at The Concourse Hotel, Madison. See details in box elsewhere in this issue.

Apr 22-23: *Symposium on Critical Care Medicine*, sponsored by the Wisconsin Society of Critical Care Medicine, at Lutheran Hospital, Milwaukee. Info: Shirley Hagen, Executive Secretary, 700 North Water St, Milwaukee, Wis 53202.

Apr 23: Head and Neck Cancer Regional Conference, Woodruff. See details in box elsewhere in this issue.

Apr 27: Head and Neck Cancer Regional Conference, Green Bay. See details in box elsewhere in this issue.

University of Wisconsin-Madison

Ophthalmology Current Concepts Seminar

Lectures and workshops in all subspecialty areas

Sponsored by Department of Ophthalmology Faculty, University Hospitals, Madison, Wisconsin; and Davis & Duehr Eye Clinic Staff, Madison, Wisconsin

March 31-April 2

Conference fee: $50

For further information contact:

Frederick Brightbill, MD
Dept of Ophthalmology
1300 University Avenue
Madison, Wisconsin 53706

608/262-3835

THE DEPT OF SURGERY OF THE CHICAGO MEDICAL SCHOOL will sponsor a symposium on "Cancer of the Breast" on Sat, April 30, at the North Shore Hilton Hotel in Skokie, IL.

The program will highlight the newest concepts and techniques in the diagnosis and therapy of breast cancer.

For enrollment information contact:

Ms Elaine Huffman, Symposium Coordinator
Department of Surgery
University of Health Sciences/The Chicago Medical School
North Chicago Veterans Administration Hospital
Building 50
North Chicago, IL 60064

313/473-9200 Ext 214

Apr 28-30: Seminar-Workshop in Radiology/A Comparative Evaluation: Computerized Tomography, Ultrasound and Nuclear Medicine, at The Wisconsin Center, Madison. See details in box elsewhere in this issue.

Apr 29: *Alternatives to Drug Abuse and The Grief Process,* Winnebago Mental Health Institute, Winnebago. See details in box elsewhere in this issue.

Apr 30: One-day symposium on *Basic Sciences and the Clinical Practice of Anesthesia,* at Hoffman House-Midway Motor Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

May 4: Head and Neck Cancer Regional Conference, Madison. See details in box elsewhere in this issue.

May 12: *Staff Burnout Syndrome,* Winnebago Mental Health Institute, Winnebago. See details in box elsewhere in this issue.

May 25: *Child Psychiatry Workshop,* Winnebago Mental Health Institute, Winnebago. See details in box elsewhere in this issue.

May 25: One-day symposium on *Office Dermatology* 1977, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

Jun 3: Annual Scientific Sessions of American Heart Association/Wisconsin Affiliate, at Performing Arts Center, Milwaukee. *Pre and Post Hospital Aspects of Myocardial Infarction.* Info: Ms Pat Erdmann, AHA/Wisconsin Affiliate, 795 North Van Buren, Milwaukee, Wis 53202. Tel: 414/271-9999.

Jun 25: Leukemia Society of America Medical Symposium, sponsored with the Medical College of Wisconsin, Milwaukee. Speakers: Prof Dirk W vanBekkum of The Netherlands and Dr Leon Shwartzenburg of France as well as other international and national authorities in the treatment of leukemia. Further details will appear in the April issue. Inquiries: Leukemia Society of America, 411 East Mason, Milwaukee, Wis 53202.

National Drug Abuse Conference May 5-9 in San Francisco: The theme of the 1977 National Drug Abuse Conference is "A Multicultural View of Drug Abuse." The conference, to be held May 5-9 at the Hyatt Regency Hotel in San Francisco, is chaired by David E Smith, MD; conference coordinator is Gail B Jara. Registration fee is $85. For more information, write to NDAC, 409 Clayton Street, San Francisco, Calif 94117; 415/626-6763.

1977 AMA

Mar 30-Apr 1: 30th National Conference on Rural Health, Seattle, Wash, Washington Plaza.

Jun 18-22: AMA Annual Meeting, San Francisco, Calif, Fairmont Hotel and Tower; San Francisco Convention Center—Brooks Hall.

Aug 8-13: "Medinfo '77"—2nd International Conference on Medical Computing, cosponsored by the Canadian

Ninth Annual Southeastern Wisconsin Cancer Conference
Pfister Hotel—Milwaukee
Wisconsin

The Dilemma: Endometrial Cancer (Estrogens, Diagnosis and Therapy)

April 2, 1977

8:30-9:30 am Registration

9:30-10:00 am Frank Vellios, MD, Editor-in-Chief of American Journal of Clinical Pathology, Professor of Pathology and Director of Surgical Pathology of University of Texas Southwestern Medical School, Dallas, Tex

10:00-10:30 am Darryl E R Townsend, MD, Professor of Obstetrics and Gynecology, Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, Chicago, Ill

10:30-11:00 am Coffee

11:00-11:30 am Wm T Moss, MD, Professor of Radiology, University of Oregon School of Medicine, Portland, Ore

11:30-12:00 n Carmel J Cohen, MD, Director of the Division of Gynecologic Oncology and Associate Professor Mount Sinai School of Medicine, New York, NY

12:00-1:00 pm Luncheon

1:00-2:00 pm Panel Discussion Moderator: Dr David V Foley, Chairman, Dept of Obstetrics and Gynecology, St Joseph's Hospital, Milwaukee, Wis

Credit: 3 Hours of AMA Category I. Also 3 hours of elective credit by AAFP can be attained. Cosponsored by the Medical College of Wisconsin

Conference Chairman: Frank E Berridge, MD

PATIENT EDUCATION IN THE PRIMARY CARE SETTING

Two-day conference presented by University of Wisconsin Center for Health Sciences Dept of Family Medicine and Practice and Dept of Continuing Medical Education Health Sciences Unit, University of Wisconsin-Extension

Tues-Wed/April 19-20
Concourse Hotel/Madison

Objectives: To focus national attention on the role of patient education in primary care; to present an update on the current state of the art in primary care patient education, both nationally and locally; to provide a setting for a discussion of needs and problems in effective patient education; and to enable individuals involved in the broad spectrum of primary care patient education to share their ideas, programs, resources, and research.

Chairpersons: John H Renner, MD, chairman, and Dorothy M Blobner, MS, Dept of Family Medicine and Practice, University of Wisconsin Center for Health Sciences, Madison.

Faculty: Donald Bosshart, EdD, associate director, Office of Research in Medical Education, University of Texas-Galveston; Gary Gilmore, PhD, assistant professor, Community Health Education, University of Wisconsin-LaCrosse; Lawrence W Green, PhD, associate professor and head, Division of Health Education, School of Public Hygiene and Public Health, Johns Hopkins University; H Winter Griffith, MD, associate professor, Dept of Family Practice and Community Medicine, College of Medicine, University of Arizona-Tucson; Robert L Johnson, president, National Center for Health Education, San Francisco; Nada Leman, RN, BS, patient education coordinator, Carle Clinic Association, Urbana; and Irving Shapiro, PhD, educational consultant, adjunct associate professor, School of Public Health, Columbia University-New York.

Fee: $110.

Credit: Meets criteria for Category I credit for the PRA of AMA; WAFP prescribed credit applied for; CEHs available

Further info: CME Coordinator, UW-Extension, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

UNIVERSITY OF MINNESOTA

Continuing Medical Education Programs

Spring 1977

Allergy and Clinical Immunology—March 17-19

Psychiatry (Advances in Communication Skills)—March 24-25

Thoracic Diseases—March 24-25

Current Topics in Clinical Laboratory Science—April 20-23

Topics in Geriatric Medicine—April 28-29

Glaucoma—May 2-3

Clinical Genetics—May 6-7

Practical Dermatology in Primary Care—May 12-14

Current Concepts of Heart Disease—May 20-21

Current Concepts in Radiation Therapy—May 25-27

Clinical Pharmacology and Therapeutics: A Pediatric Perspective—June 1-3

Clinical Hypnosis—June 3-4

Management of Colorectal Problems for the Family Physician—June 3-4

Vascular Surgery—June 13-15

National Pediatrics Conference—June 16-17

Management of Cerebral Palsy—June 13-18

For further information contact:

Ruth K McIntyre
Continuing Medical Education
Box 293
Mayo Memorial Building
University of Minnesota
Minneapolis, Minnesota 55455

Equal Educational Opportunity

Medical Association, International Federation for Information Processing; and World Health Association.

Nov 10-11: AMA 16th National Conference on Physicians and Schools, Regency Chicago, Chicago.

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Dec 20-23: AMA National Leadership Conference.

Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

Head and Neck Cancer Regional Conferences

The Head and Neck Cancer Network has planned three regional conferences for this spring at the Howard Young Center in Woodruff, April 23; St Vincent's Hospital in Green Bay, April 27; and Memorial Union South, Madison, May 4. Each conference will begin at 9:00 AM and conclude at 3:15 PM. Faculty for each will be different, but there will be lectures in the morning on the head and neck exam and screen for family practitioners and dentists, and workshops in the afternoon on the head and neck exam and prosthodontistry. Each conference program follows:

Howard Young Medical Center, Woodruff—Saturday, April 23
Moderator: John V Flannery III, MD, Wausau

9:00 AM *The Head and Neck Examination,* by John V Flannery III, MD Wausau

9:25 AM *The Oral Cavity Screen,* by Frank Tautin, DDS, Wausau

10:00 AM *Efficient Method of Head and Neck Examination for Family Physicians and Dentists,* by J Gary Sack, MD, Madison

10:50 AM Guidelines for Head and Neck Cancer Therapy, by Jacob H Martens, MD and Leonard H Wurman, MD, Wausau

12:00 N Luncheon AFTERNOON WORKSHOPS: 1:00-3:15 PM

St Vincent's Hospital, Green Bay—Wednesday, April 27
Moderator: John Mills, MD, Green Bay

9:00 AM *Examination and Lesions of the Ear, Nose and Throat,* by Sherwood Vander Woude, MD, Green Bay

9:50 AM *New Techniques of Office Examination of the Larynx and Nasopharynx,* by David M Wineinger, MD, Green Bay

10:30 AM *Complications of Radiotherapy of the Head and Neck,* by John F Mokrohisky, MD, Green Bay

12:00 N Luncheon

1:00 PM *Prosthodontist Role in Reconstruction of Head and Neck Patients,* by Robert Tang, DDS, Wauwatosa

Moderator: David M Wineinger, MD, Green Bay

2:05 PM *Prosthodontist Role in Reconstruction of Head and Neck Patients,* by Robert Tang, DDS, Wauwatosa

1:00 PM *Practical Application of the New Techniques of Office Examination of the Larynx and Nasopharynx,* by Charles Ford, MD, LaCrosse; David Wineinger, MD, Green Bay; and Richard Titulaer, MD, Waukesha

2:00 PM *Practical Application of the New Techniques of Office Examination of the Larynx and Nasopharynx,* by Charles Ford, MD, LaCrosse; Sherwood Vander Woude, MD, Green Bay; and Richard Titulaer, MD, Waukesha

Memorial Union South, Madison—Wednesday, May 4
Moderator: James H Brandenburg, MD, Madison

9:00 AM *The Head and Neck Examination,* by James H Brandenburg, MD, Madison

9:25 AM *The Oral Cavity Screen,* by Paul J Correll, DDS, Madison

10:00 AM *An Overview on the Surgical and Radiotherapeutic Management of Head and Neck Malignancies.* Discussion: James H Brandenburg, MD; John K Scott, MD; Antonio Bosch, MD; Paul J Correll, DDS; and Adrian D Duszynski, DDS, Madison

12:00 N Luncheon AFTERNOON WORKSHOPS: 1:00-3:15 PM

For reservations contact the Wisconsin Division of the American Cancer Society, Inc, 611 North Sherman Avenue, Madison, telephone 1-608-249-0487.

SEMINAR-WORKSHOP IN RADIOLOGY
A Comparative Evaluation: Computerized Tomography, Ultrasound and Nuclear Medicine

Thurs-Sat, April 28-30
The Wisconsin Center, Madison

Topics include the comparative potential of nuclide scanning versus computerized tomography in the detection of central nervous system lesions in adults and children and the physical, technical and engineering features of current commercially available CT and ultrasound equipment.

Conference fee: $175. CME credits in Category I of AMA-PRA; ACR credit applied for. UW-Extension offers CEHs.

Presented by the Department of Radiology, Center for Health Sciences, University of Wisconsin-Madison and Continuing Medical Education, Health Sciences Unit, University of Wisconsin-Extension. CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

Wisconsin Society of Critical Care Medicine

Second Annual
CRITICAL CARE SYMPOSIUM

Fri-Sat, April 22-23
Lutheran Hospital, 2200 Kilbourn Ave, Milwaukee

General Chairman: Guenther P Pohlmann, MD, Columbia Hospital, Milwaukee.

Guest Speaker: Max Weil, MD, USC School of Medicine, Shock Research Unit, Los Angeles, Calif.

Topics: Acute Heart Problems, Acute Kidney Problems, A Potpourri of Acute Problems of the Critically Ill Patient.

Special Feature: Consultation with the Faculty one hour each day in small groups.

Eligible to attend: Physicians, registered nurses, and others intimately involved in Critical Care upon recommendation of the Director of the Unit.

Fees: Physicians, $50; Nurses, $25; Interns and Residents, $25. Lunch on Friday is included.

Application pending for credit in Category 2 of the AMA-PRA.

Make checks payable to: Wisconsin Society of Critical Care Medicine, Shirley Hagen, Executive Secretary, 700 North Water Street, Suite 616, Milwaukee, Wis 53202.

CONTRIBUTIONS—CES FOUNDATION
January 1977

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for January 1977.

Unrestricted
Jane W Moir, MD; Anonymous—*Voluntary contributions*

Restricted
Albert Popp, MD—*Popp Student Loan Fund*
Thomas W Tormey Jr, MD—*Tormey Memorial Medallion Fund*
A H Robins Company, Inc—*Guest Speakers Fund*
James Albrecht, MD—*Medical Student Summer Externship Program*
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Burroughs Wellcome Company; Outagamie County Medical Auxiliary—*Museum of Medical Progress*
Membership Dues—*Aesculapian Society*

Memorials
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Dr-Mrs MF Huth—*Judge Carl Flom*
State Medical Society—*Lester Sell; Howard Parkhurst, MD; John A Grab, MD; Carlton J Ryan, MD; HW Christensen, MD*

Winnebago Mental Health Institute, Winnebago, Wis
March-June 1977 CME Programs

Mar 17: "Psychopharmacology Workshop," guest speaker, Robert O Friedel, MD, assoc prof of Psychiatry and Pharmacology; Dir, Division of Psychopharmacology, Univ of Washington.

Registration:	8:45 - 9:30	
Part I	9:30 - 12:00	Antipsychotic & Antidepressent Agents
Part II	1:15 - 3:00	Antianxiety Medications
Part III	3:00 - 4:00	Panel Discussion

Acceptable for 6 credit hours in CME Programs

Apr 29: "Alternatives to Drug Abuse" and "The Grief Process," guest speaker, John Brantner, PhD, Univ of Minnesota, professor, Dept of Clinical Psychology.

Part I	10:30 - 12:00	Alternative to Drug Abuse
Part II	1:15 - 3:00	The Grief Process

Acceptable for 4 credit hours in CME Programs

May 12: "Staff Burnout Syndrome," guest speaker Christina Maslach, PhD, prof, Dept of Psychology, Univ of California, Berkeley.

Part I	10:30 - 12:00	Current Research and Findings on staff burnout syndrome
Part II	1:15 - 3:00	Preventative measures for one staff burnout syndrome

Acceptable for 4 credit hours in CME Programs

May 25: "Child Psychiatry Workshop," guest speaker, Domeena Renshaw, MD, assoc prof, Dept of Psychiatry, Loyola University

Registration:	9:45 - 10:30	
Part I	10:30 - 12:00	Psychiatric Emergencies with children and adolescents; Child Psychopharmacology
Part II	1:15 - 3:00	Suicide and Depression in Children
Part III	3:00 - 4:00	Panel Discussion

Acceptable for 6 credit hours in CME Programs

Info: Steve Kearney, Dir of Educational Services, Winnebago Mental Health Institute, Box H, Winnebago, Wis 54985. Phone 414/235-4910, ext 316.

NEWS YOU CAN USE

NEW RULES ON STERILIZATION PROCEDURES

Specific regulations have been issued by HEW regarding non-emergency and non-therapeutic sterilization procedures. No Medicaid payments can be made for sterilizations of individuals under age 18 years or individuals legally incapable of consenting to such a procedure. Medicaid payment can be made for sterilization procedures performed on anyone 18 years or older *only* if the following requirements are met: (1) the sterilization must be the result of a voluntary request *made by the recipient;* (2) an informed consent must be obtained from the recipient by means of a completed "Consent to Sterilization" form; (3) the recipient must be advised at the outset and prior to solicitation or receipt of consent, that no program or project benefits to which he or she might otherwise be entitled, may be withdrawn or withheld by reason of his or her decision *not* to be sterilized; and (4) the sterilization procedure *must not* be performed earlier *than 72 hours* following the giving of informed consent. All claims for non-emergency or non-therapeutic sterilization must be accompanied by a completed "Consent to Sterilization" form. Claims *not* accompanied by this form will be returned to the provider.

ONE YEAR, AND ONE YEAR ONLY!

Effective March 1, 1977 physicians and other providers in Wisconsin have just one year to file claims for services provided Medicaid (Title 19) patients. The previous filing limit has been two years. For all services provided after March 1, 1977 claims must be filed no later than one year from date of service. For all services provided prior to September 1, 1976 claims must be filed with WPS or Surgical Care (Wisconsin's Medicaid administrators) not later than September 1, 1977.

ANTICOAGULANT SUGGESTED IN SURGERY

The American Heart Association has recommended the anticoagulant drug heparin be given to certain patients to prevent formation of blood clots, or thrombi. The AHA said such preventative therapy could save 4,000 to 8,000 lives annually. The AHA recommends that low doses of heparin be given to patients over 40 years with normal blood who undergo elective abdominal or chest surgery. An article on "Monitoring Heparin Therapy" appears in the SCIENTIFIC MEDICINE section of this issue. ■

WARNING TO PHYSICIANS REGARDING CONTROLLED SUBSTANCES

Following discussion at a recent meeting of the Controlled Substances Board, the State Medical Examining Board has issued the following warning to physicians regarding controlled substances: "Recent data has made it evident that there exists in Wisconsin a substantial problem regarding the prescription of Schedule 2 drugs, despite long-term, continuing efforts toward physician education by the State Medical Society. The magnitude of the problem is, unfortunately, larger than might be hoped. While we in no way intend to threaten ethical practitioners (who should not feel threatened anyway), we feel it only fair to serve notice that the Medical Examining Board and the Drug Enforcement Administration intend to investigate situations in which there is reasonable reason to infer substantial overprescription or other abuse of Schedule 2 drugs."

HEW: ANOTHER $100,000 LIST

The US Department of Health, Education, and Welfare (HEW) last month released the names of 34 Wisconsin medical providers who received more than $100,000 in Medicare payments in 1975. As might be expected, HEW mishandled the release of the names. Some physicians were listed as individuals, apparently receiving large amounts, when in fact, they were members of physician groups, and the amounts listed were actually paid to the entire group. Charles J Picard, MD, Superior, SMS president, told HEW, "Remember, these payments are for legitimate services rendered. If HEW thinks that any physician on this list is guilty of fraud, then HEW should say so. The manner in which these names were released implies guilt by innuendo."

SMS OPPOSES LEGALIZATION OF LAETRILE

The State Medical Society joined many other medical groups in opposition to the legalization of Laetrile as a cancer-fighting drug, at a hearing at the State Capitol last month. John K Scott, MD, Madison, chairman of the SMS Committee on Cancer, told the Assembly Health and Social Services Committee that most Wisconsin physicians oppose the use of Laetrile. Doctor Scott told legislators, "The possible, slight psychological benefit of a worthless remedy to a patient with advanced cancer far, far outweighs the catastrophe of a potentially curable patient using Laetrile instead of proven, effective treatment." He added, "Physicians, just like others, sometimes suffer from cancer. If there was a 'magic' answer to the problem it is unlikely that it would have escaped our endorsement and immediate use."

THREE DRUGS TO BE ADDED TO GENERIC LIST

The Wisconsin Drug Quality Council has recommended three additional generic drugs for listing in the Wisconsin Drug Formulary: chloral hydrate, a sedative used in sleeping capsules; isoniazid, an antibacterial used in the treatment of tuberculosis; and oxytetracycline, an antibiotic. The additional listing of these drugs to the Formulary will take effect August 1.

SMS SUPPORTS IMPROVED INSURANCE BENEFITS

The State Medical Society has testified before legislative committees in favor of three bills designed to improve health insurance benefits for Wisconsin citizens. One measure would establish a catastrophic illness plan, where people incurring severe medical expenses may obtain state aid to meet abnormally large financial responsibilities. Another measure would require the State to create minimum levels of benefits for disability insurance policies. The third measure would direct the State to establish a mandatory health insurance risk-sharing plan for uninsurables and low-income families. The latter measure was first proposed by SMS four years ago.

THE *MILWAUKEE JOURNAL* "SORE THROAT" SERIES

The SMS has requested the opportunity for ex-officio participation in the recently announced State Medical Examining Board investigation into the Milwaukee area "sore throat" incidents. Posing as a young Medicaid patient, a *Milwaukee Journal* reporter visited five Milwaukee area physicians complaining of a non-existent sore throat. A subsequent series of articles alleged the physicians rendered treatment and medication in a hasty manner for a non-existent illness. The Society believes the articles are misleading and totally ignore the fact that physicians must place a great emphasis on what the patient tells them for proper treatment of any illness.

SMS OPPOSES CHIROPRACTIC INSURANCE BILL

Society representatives strongly opposed a bill before the Legislature which would require health insurance policies to cover chiropractors. SMS spokesmen pointed out that physician and chiropractic services are not equal. It also was pointed out that the bill allows chiropractors to certify disability, but apparently without restriction. Lawmakers also were told mandatory coverage destroys the right to contract on group plans. And, the SMS representatives said physicians believe the costs associated with mandatory coverage would be excessive. ■

the wisconsin medical journal

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How Long Private Health Insurance?

THE ORIGINAL idea of private health insurance was to offer protection to an individual against large hospital costs. For this he paid a much smaller premium on a predictable basis. In some ways it could be compared to the fire protection companies of the early days of America; here too a fee was paid for an iron plaque to nail to your house; then if fees were kept current, the fire department would service those with plaques on their walls, in the case of catastrophic fire. The analogy can be stretched too far, but we all know what has evolved from this early entrepreneural system.

In the world of health insurance the first attempts were limited in two ways: only hospital care was insured, and only certain healthy individuals were insured. On an actuarial basis then, fair premiums could be figured out and those fortunate individuals who passed the physical and paid the fee could feel safe. Now comes the public pressure, without which no political action can be sustained. The first move was away from hospital care only, and to include outpatient care; it no longer became necessary to "hospitalize" a patient to approach his total health assessment and have it covered by insurance.

There are still large areas of resistance to coverage of outpatient care, in spite of clear evidence of the relative efficiency for the general public health; that is, outpatient care when appropriate and hospital care when appropriate, but there has been practically no backward movement. The second move has been toward universal coverage, protection for any human being, even at a higher fee (or covered by taxes, as proposed in the current Wisconsin Legislature) whether the person once spilled sugar, had an anginal episode, or had the courage to seek help for faulty life patterns (rather than deny them, drink them into oblivion, or harass others with their misconceptions). Now, of course, the actuarial base will change to cover all risks, even as it had to change to cover outpatients. For example, studies in the east have shown that to include an outpatient psychiatric treatment benefit required an additional yearly premium of about $10 per person. Studies on the west coast have shown that allowing psychiatric coverage for all who ask cuts down on overall medical needs by a significant percentage over a ten-year study period. Now it appears that the same thing might occur if we ceased to exclude the so-called "bad risks" and extended our care even to those who have experienced some stress with or without physiological symptoms. At least physicians can be aware of the movement from "fire signs to fire departments." Otherwise we may use what small political clout we do have in a wasteful manner; and with greater perspective we can better work with our own Physicians Alliance.—RH

A Test For What?

IT WAS WITH great dismay that I witnessed an interview, some weeks ago, on the *Today Show*. Two physicians were being questioned about the ever-surging demand for "competency" in medicine. When the subject of recertification tests came up, this anecdote was told by one of the physicians: one of several hundred taking the "test" did not pass. When asked what happened then, the physician answered that the physician who had failed would be allowed to take the test again in a year. Then the questioner asked, with what I believe to be growing panic, a decidedly leading question: but was he allowed to practice during that year? Well, the answer was "yes," but it was quite clear that did not satisfy the questioner; while no more discussion followed, to my dismay, the point had been made that failing a given test implied that a physician should not practice, and that the medical profession was severely lax if it allowed this to happen.

We all know that there is a severe difference between questions and tests based on academic research, and questions and tests based on clinical practice of medicine including utilization of research findings. We all know that competency in one area does not at all mean competency in the other; town and gown are neither "right" but are certainly different.

Recently I scored in the center percentile (well if you must know, 48th percentile) of a test prepared by

my national professional association, ostensibly covering all practitioners both clinical and academic. Having been seven years in academe I was able to squeak by, but in reading over the questions I found not more than four or five that related at all to what I have been doing, competently I like to think, for my last thirty clinical years.

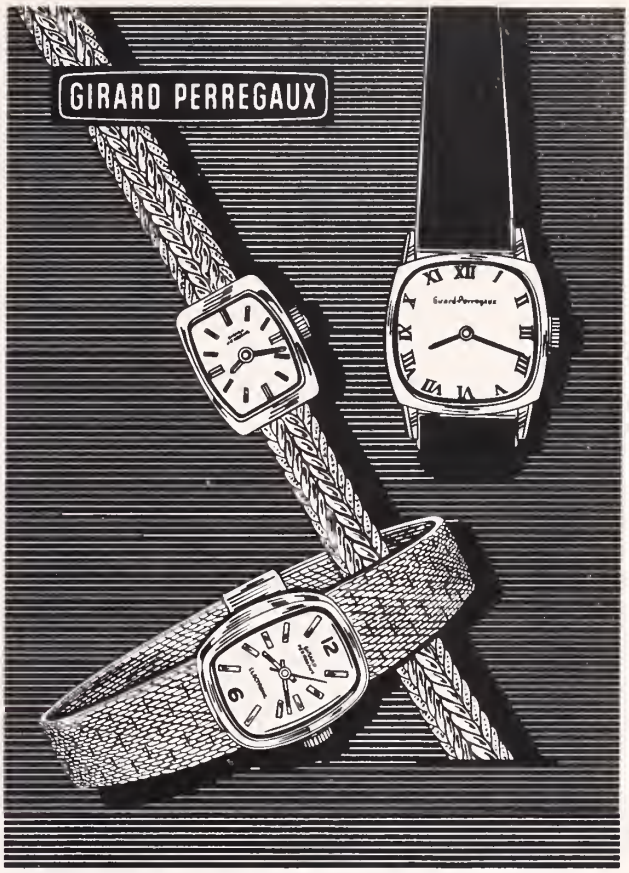
Unless we wish to see a substantial change in how we spend our professional time in the very near future, we will need to handle our public relations better than on the show discussed above. We more particularly need to disabuse ourselves, within our own profession and within each specialty, of the peculiar assumption that competency in medicine can be measured by (a) one and three; (b) two and four; (c) all the above. I choose none-of-the-above, and resent being asked the question, when its answer presumes to decide whether I should be allowed to practice. Thus, one more danger comes into focus.—RH

Coming Attraction: Catch 22

WATCH FOR a scientific paper to be published this summer in this Journal, in which the difficult problem of "which disease do you want" is adeptly illustrated by Gary Guten and Donald Harvey of Milwaukee. Your surprise and pleasure in reading the paper will not be spoiled by early reporting. However, we all have witnessed the problem they raise.

For example, a physician friend of mine needed to do his Williams exercises for a painful back; doing them with excess vigor produced an exacerbation of his hemorrhoids, requiring surgery. Classic example of this sort of Catch 22 was the dilemma which arose when heavy filter cigarettes first came out: which do you choose, cancer from unfiltered cigarettes or hernia from drawing through the filter?

Physician readers can think of many other "cruel" choices in medicine. Read of another dilemma in which their patient did not agree with Guten and Harvey—coming in a summer issue. Watch for it.—RH ■



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Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin.

Supports End to Mandatory Retirement Age

To Lt Gov Martin Schreiber: We noted with interest your recent call for an end to mandatory retirement ages in this state and country. I want you to know that the State Medical Society of Wisconsin supports you in this position. In fact, the Society's Division on Aging adopted a statement in 1968:

> "Arbitrary retirement based solely on chronological age is widely regarded as undesirable in a free society which places a premium on individual accomplishment and dignity . . . The American Medical Association favors flexible policies which utilize the talents and abilities of employees as long as they are willing to work and are productive. Compulsory retirement and employment policies which reject workers solely because of age waste valuable human resources, and contribute to physical and mental illness among the aged. The State Medical Society strongly endorses this statement of policy . . . The State of Wisconsin . . . should provide leadership to industry and labor in this state by the adoption of truly flexible programs of retirement which recognize individual worth and initiative."

Our position on this matter remains as strong as it has been since this statement was adopted. If we can be of further assistance to you in ending the mandatory retirement ages, please feel free to contact us.

CHARLES J PICARD, MD
President
State Medical Society
of Wisconsin

Feb 1, 1977

To Charles J Picard, MD: Thank you for your recent letter regarding mandatory retirement.

I appreciate your support of my position on this issue. Like the SMS, the Ombudsman Program has found that mandatory retirement can affect the psychological and financial wellbeing of older workers. I have enclosed a copy of a recent press release which further describes my feelings for your information and review (see below).

MARTIN J SCHREIBER
Lieutenant Governor
State of Wisconsin

Feb 16, 1977

MADISON, WI—Lieutenant Governor Martin J Schreiber today (January 16, 1977) requested congressional approval of a bill outlawing mandatory retirement. "A law preventing our older workers from being forced to retire simply because they reach the arbitrary age of 65 must be enacted to eliminate the legally sanctioned practice of age discrimination," Schreiber said.

In a letter to the US House of Representatives Subcommittee on Equal Opportunities, Schreiber argued that age discrimination laws, which only protect a worker until he reaches his 65th birthday, have legitimatized discrimination against employees over 65.

"In our society, voluntary retirement, with adequate pensions, is both socially desirable and economically feasible," Schreiber said. "But mandatory retirement when based upon age alone is unfair, unnecessary, and wasteful of valuable skills and experience."

Schreiber cited studies indicating forced retirement of skilled workers reduces the value of national goods and services by as much as $10 billion annually. "In the interest of the national economy and the financial security of our elderly, Congress should give immediate attention to ending mandatory retirement," Schreiber said.

Schreiber suggested that a Harris survey which indicated that 86 percent of the American people oppose forced retirement at an arbitrary age is a clear mandate for a thorough and prompt congressional evaluation of the present system of involuntary retirement.

"Many of our older workers are forced to give up their lifelong occupations and literally fight for survival on permanent fixed incomes because they have reached the mandatory retirement age. Every older American," Schreiber said, "should have the choice of continuing to work as long as they are able, or to retire when they choose, on an adequate income."

Assails Membership Dues Structure

To the Editor: The January 1977 edition of the Medical GREEN SHEET was interesting reading, especially the last segment related to the State Medical Society dues.

If one substracts one-third of the annual State Medical Society's dues as representing the portion related to Physicians Alliance Division expenditures, the remaining $200 per year is still in excess of the total annual dues of the average state medical society, including Wisconsin, presuming that the other state medical societies have no expenses at all for state lobbying efforts.

The actual State Medical Society's dues of a Milwaukee county physician is not the $300 per year that you list but in reality is $850 per year since Wisconsin is one of the five states in this nation which requires a physician to belong to the American Medical Association as well as to his county medical society in order to belong to the State Medical Society.

The State Medical Society of Wisconsin can reduce significantly the cost of practice in Wisconsin by eliminating this archaic requirement of belonging to all three medical organizations and by efforts to reduce the cost of the state malpractice insurance including the reduction of the fee paid to the agent writing the malpractice insurance but providing minimal if any service.

ROBERT B FRUCHTMAN, MD, SC
Milwaukee, Wisconsin

January 25, 1977 ■

SMS membership retirement plan

The State Medical Society has successfully reached agreement with all interested parties to protect the SMS Membership Retirement Plan from several potentially adverse effects from changes in the Employee Retirement Income Security Act (ERISA). ERISA was designed to protect and improve the coverage for those participating in qualified plans. The Act necessitated amendments to many of these plans. However, proposal changes to bring corporate (including professional service) plans into compliance might well have had adverse, rather than beneficial, results. In the case of the SMS Member Plan, the suggested modifications might well have: (1) limited the income base upon which benefits are calculated for employees; and (2) had an adverse tax impact upon a physician's estate if he had named a trust rather than a natural person as his beneficiary.

Following review by SMS legal counsel and recommendations from the Committee on Economic Medicine, the Council adopted a resolution calling for correction of the proposed amendments to eliminate the adverse effects. Through the assistance of the Society's insurance consultants, the SMS has been advised the funding agency and the IRS are agreeable to the proposed corrections.

When all of the documents have been appropriately cleared and filed, those who are participating in the SMS program will receive explanatory information, as another benefit of Society membership. ■

SMS Variable Annuity Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.35 as of January 31, 1977. ■

WHCRI plans drug evaluation

Wisconsin Health Care Review, Inc (WHCRI) has announced plans to develop a comprehensive proposal of drug evaluation in Wisconsin nursing homes.

The proposal will be developed in coordination with the State Medical Society of Wisconsin, Wisconsin Pharmaceutical Association, and Title 19 (Medicaid) fiscal intermediaries.

Intent of the proposal is to involve physicians and pharmacists in performing review of patterns of drug usage by patients in long-term care facilities.

Cameron Brown, executive director of WHCRI, says the primary objective will be to "achieve high standards of patient care in nursing homes through promotion of rational drug therapy."

WHCRI has hired a Madison pharmacist, Dick Hansen, to develop the formal proposal to the State Department of Health and Social Services (DHSS) for funding. WHCRI currently conducts an Independent Medical Review (IMR) program in Wisconsin, under contract with DHSS. WHCRI provides physicians for review of patient care in nursing homes. ■

Members attention! Update records

The SMS Membership Department has an ongoing program for keeping members' records accurate and current. But occasionally information fails to get recorded in the members' files, or additional information is needed to meet current demands.

The Membership Department and the *Wisconsin Medical Journal* are verifying members' home and office addresses (and mailing address), their primary and secondary specialties, and whether certified and in what specialty.

ALL MEMBERS ARE REQUESTED to complete the form below and return promptly to the Membership Dept. This information is most important to physicians to assure proper listing. ■

TO: SMS Membership Department, Box 1109, Madison, Wis 53701

I submit the following information for your records:

NAME (Please print or type) _____ NAME (Please print or type) _____

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CITY _____ ZIP CODE ☐ CITY _____ ZIP CODE ☐

Please indicate your mailing address for Society communications by checking appropriate box above.

PRIMARY Specialty _____ SECONDARY Specialty _____

☐ CERTIFIED in _____ (Specialty) DATE _____

MEMBER OF _____ COUNTY MEDICAL SOCIETY

COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

January 15, 1977 — Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Correll at 12:40 pm on Saturday, January 15, 1977, at the State Medical Society.

Voting members present: Chairman Correll, Vice-chairman Edwards, Doctors Pittelkow, Williams, Boulanger, JJFoley, Nielsen, LaBissoniere, Mullooly, Huth, Crowley, Tuftee, Waterhouse, Rohde, JJKief, Peters, Smejkal, Haskins, Picard, Larsen, Stuff, and Motzel.

Others present (part or entire): Doctors Nordby, Derus, Twelmeyer, Collentine, Dettmann, Scott, HJKief, Maurer, Janssen, Lubitz, Kempthorne, Grover, Kabler, Parker, Biek, Hank; Dr and Mrs Schaeffer, Mrs Mielke; Messrs Thayer, Brower, Simms, Johnson, Wendle, LaBissoniere, Brown, McIntyre, Horton, Koenig, Bontrager, Lockerbie, Brodersen, Schweers; Mrs Bartel and Miss Pyre.

2. Approval of Minutes

Minutes of the November 13, 1976, meeting were approved on motion of Doctors Smejkal-Peters, carried.

3. Report of Executive Committee

A. Status Report on Application for Incorporation of WPS

The committee reported to the Council that it did not consider the December 31 letter from the Commissioner's office as responsive to the application filed with the Commissioner in October and a subsequent conference requested by the Society in an effort to secure action on the application. It has authorized staff to meet again with Mr Wilde and report back to the committee in a month as to progress that has been made.

B. Establishment of Interstate Relationships

On motion of Doctors Williams-Huth, carried, the Council deferred action on the question of rejoining the North Central Conference or remaining with another coalition of states pending opportunity for members of the AMA delegation to evaluate the matter.

C. Sponsored Tour Abroad

On motion of Doctors Picard-Edwards, carried, the Council approved the recommendation that the Society endorse a sponsored tour abroad for members at special group rates, through Dittmann Tours or similar organization, provided the cash equivalent of special considerations such as complimentary tickets be paid to the Society's general fund. The motion was amended by Doctors Nielsen-Williams that this not involve any significant time of Society staff; motion carried as amended.

D. Wisconsin Center for Public Policy

This organization is proposing a series of one day symposia for legislators and others designed to highlight specific policy initiatives in key areas, including health care. On motion of Doctors Picard-Edwards, carried, the Council authorized cosponsorship with other health care organizations, and up to $1,500 in "start up" funds from the contingency account, providing the Physicians Alliance Commission also approves participation in the proposed health care symposium.

E. Ethics of Physician Participation in Criminal Investigations

The committee reviewed correspondence from a Wisconsin physician objecting to medical personnel in a correctional setting being involved in investigations, such as searches of body cavities for drugs, which creates a serious credibility gap between physician and inmate-patient. On motion of Doctors Picard-Nielsen, carried, the Council approved the recommendation that no person employed as the personal physician for inmates of a correctional institution should be required to act as an officer of the law; that another physician should be employed for such body searches.

F. Northwestern University Graduate Program in Medical Association Management

On motion of Doctors Picard-Larsen, carried, the Council approved the recommendation that the Society not make a separate contribution to the AMA for financial support of this graduate training program; that such funding should come from AMA dues income to spread the source among all members of the federation.

G. Planning/Priorities/Goals Retreat for the Council

On motion of Doctors Picard-Williams, carried, the Council approved the suggestion that a special meeting without a structured agenda be given a one-time trial, and requested the committee to report back with a specific proposal and fiscal note.

H. Survey of Medical Assistants by Lakeshore Technical Institute

On motion of Doctors Picard-Huth, carried, the Council accepted the committee's report that the Society will endorse a proposed survey of randomly selected physicians and medical assistants, which had been reviewed by the physician advisors to the Medical Assistants Association, intended to aid the Institute in curriculum emphasis in its accredited course of studies for medical assistants.

I. Nutrition Education Program

The Wisconsin Dental Association's health education committee has requested that the Society join in an effort to remove junk foods from school vending machines and help educate the public in matters of nutrition. On motion of Doctors Picard-Stuff, carried, the Council supported the general position and referred the proposal and its implementation to the Commission on Public Information to work with the Dental Association.

4. Wisconsin Drug Quality Council

Drs William J Maurer, Marshfield, and William C Janssen, Milwaukee, the physician members of the Drug Quality Council nominated by the Society, reported for information on the manner in which drugs are being selected for inclusion in the Drug Formulary under the generic substitution law.

5. Guidelines for Implementation of Joint Practice of Physicians and Nurses

Doctor Kabler, co-chairman of the Joint Practice Committee, reported that since discussion and deferral of action on the guidelines in November, they had been approved in a reversal of action by the Executive Committee of the Wisconsin Nurses Association. He proposed that the Council approve the guidelines as presented by the Joint Practice Committee with the understanding that they will be under continuing review and that such changes as may be proposed will be returned to the Council for consideration. Such motion was made by Doctors Edwards-Stuff.

Considerable discussion ensued in which Doctor Williams raised objections to wording in the guidelines (including material taken from a Statement on Joint Practice previously approved by the Council which referred to "new needs and methods of providing care.") He urged, in essence, that the Council state a preference for the "present model" and request the committee to continue its studies of developing a more effective type of joint practice and expansion of nurses' responsibilities within that model.

The motion of Doctors Edwards-Stuff was voted upon by a show of hands and defeated 10-9.

On motion of Doctors Williams-Edwards, carried, the Council requested that the Joint Practice Committee continue to explore methods of expanding the role of the nurse in a practice setting based on the present model; that it serve as an information gathering and research committee; that it develop papers to advise physicians and nurses how to proceed with joint practice under the present law; and that it serve as an advisory committee to those who desire it.

Doctor Kabler indicated his belief that he should be replaced as co-chairman and member of the committee. On motion of Doctors Williams-Nielsen, carried, the Council requested that this be delayed and discussed at the next meeting.

Prior to adjournment, Chairman Correll stated that he had been given a notice of resignation by Doctor Kabler and indicated to the Council that he would take it under advisement.

6. WHCRI-WisPRO

The following recommendation of a special committee of the Council was presented for discussion:

"That the Council strongly recommend and request that WHCRI immediately take all necessary and appropriate steps to separately incorporate WisPRO with the Boards of Directors of the two organizations merged or overlapping to the extent feasible and allowed by federal law; the corporate bylaws of each being as identical as possible; with non-PSRO mandated programs executed under policies established by WHCRI; and with a single staff to serve both corporations."

At the chairman's request, Mr Horton presented the schema for an organizational structure to implement this recommendation, with minor emphasis on the conduct of operations of separate corporations by a single executive director and staff.

There was considerable discussion, with questions and suggestions as to alternate resolutions. Doctors Rohde-Peters moved that the status quo be retained and that a committee be appointed to study and report to the House of Delegates for it to resolve the situation. The motion lost.

Doctors LaBissoniere-Edwards moved adoption of the report and recommendation (quoted above) of the special committee.

Dr George Hank presented a proposed plan of operations to involve WHCRI, the two PSROs and other interests. This was felt to go beyond the basic organizational question before the Council.

Doctors Kief-Motzel moved amendment of the motion so that the recommendation would be abbreviated to read: That the Council strongly recommend and request that WHCRI immediately take all necessary and appropriate steps to separately incorporate WisPRO.

The amendment lost and the motion of Doctors LaBissoniere-Edwards carried. Doctor Peters asked to be recorded as abstaining.

7. Report of Finance Committee

Doctor Edwards reported that both investment counselors and actuaries for the Pension Plan had presented favorable reports on portfolio activity and plan valuation. The committee declared a 6% interest rate on accumulation accounts for 1977, and clarified earlier action to make the Plan available, at the option of the managing committee and trustees, to employees of sponsor-employers other than SMS, such as WPSIC, WHCRI and WisPRO, provided adequate indemnification is given.

The committee discussed and basically disagreed with the proposal that AMA do its own dues billing and collecting. It recommended that the Society staff develop a position paper in response to the AMA Board of Trustees acknowledging the AMA's problem and suggesting that it form a special task force, including representation by medical society executives, to develop a uniform membership systems program for county, state

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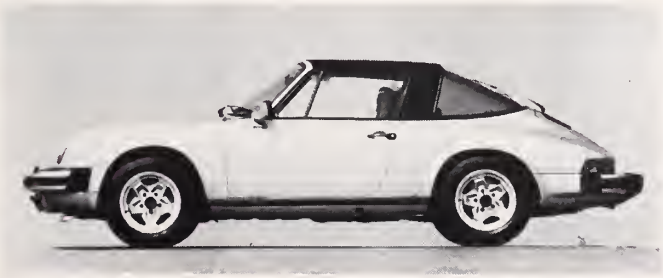

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and AMA membership recruitment and retention. This would include standard membership terminology, billing, collecting and reporting procedures, and the task force would assist in enlisting support for implementation of the approved membership system.

On motion of Doctors Edwards-Williams, carried, the Council approved the above recommendation to the AMA.

The committee also approved expenditure of up to $5,000 from previously authorized funding from the contingency account to proceed with a survey plan to determine the feasibility of a group purchasing service for members.

8. Committee on Economic Medicine

Doctor LaBissoniere reported that the committee had reviewed problems concerning the Keogh Plan arrangement with Prudential involving legal technicalities and conflicts between ERISA/IRS and Prudential/SMS legal counsel.

On motion of Doctors LaBissoniere-Rohde, carried, the Council approved the recommendation that desired changes in the SMS member retirement plan be transmitted to Prudential in a resolution to be prepared by legal counsel, as a mandate from the Council on behalf of the membership.

The committee also reviewed and reported status of insurance programs for members, including AD&D, Banker Life, overhead expense insurance, and disability income. The committee noted that while most states have considered a society-operated liability insurance program, only a few have pursued this as they had no alternative.

On motion of Doctors Smejkal-Huth, carried, the repor was accepted.

9. Council Nominating Committee

On motions duly made, seconded and carried, the following were appointed to vacancies on commissions/committees

Jack D Edson, MD, Eau Claire, Commission on Governmental Affairs

James M Huffer, MD, Madison, Commission on Peer Review

George H Handy, MD, Madison, Committee on Schoo Health

10. Committee on Evaluation of Delivery and Cos of Medical Care

Doctor Waterhouse commented on the committee's targe areas as listed in December 17 minutes; announced that the next meeting would be on February 4 with representatives from the AMA, and that any members of the Council were welcome to attend.

On motion of Doctors Smejkal-Williams, carried, the committee report was accepted.

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11. Commission on Governmental Affairs

Doctor Lubitz discussed a report distributed to the Council on December and January meetings and activities of the Commission and Alliance staff related to legislation.

On motion of Doctors LaBissoniere-Pittelkow, carried, the Council approved two recommendations from the Commission:

A. That the chairman of the Commission on Governmental Affairs be an ex officio voting member of the Physicians Alliance Commission.

B. That the chairman of the Committee on Federal Legislation of the Commission on Governmental Affairs be an ex officio voting member of that commission.

Doctor Lubitz also outlined the general terms of certificate of need legislation which the commission has requested staff to draft, and which will be presented to the Council for approval prior to introduction.

On motion of Doctors Rohde-Boulanger, carried, the report was accepted.

12. Physicians Alliance Commission; Contract with Veterans Administration

Mr Simms commented on an informational report distributed to the Council on Alliance activities.

He reported the Commission's recommendation that the Council not renew the VA "home town care" contract because the volume of business is inconsequential. Over one-half of the medical fee payments were for oxygen costs. In the absence of such an agreement, the central VA office in Washington would establish the amount of reimbursement.

On motion of Doctors Mullooly-Stuff, carried, this recommendation was approved by the Council.

13. Commission on Public and Professional Affairs; Interprofessional Code

Doctor Kempthorne reviewed activities in handling grievances in recent years, and discussed concerns of the commission as to its scope of responsibility and authority as well as its name and public visibility.

The suggestion was made that one or two members of the Council meet with the commission to help formulate specific recommendations for action. The chairman stated he would take this under advisement and appoint two councilors.

On motion of Doctors Mullooly-Kief, carried, the Council, on recommendation of the commission, approved a revision of the Interprofessional Code for the State Bar of Wisconsin and State Medical Society, subject to concurrence by the State Bar Board of Governors.

14. WPS Commission

Mr Koenig first reported the facts behind an erroneous recent story in the *Capital Times* which bore the headline "WPS blocks Medicaid audit."

A. Current Operations Report

This report covered financial and enrollment results during 1976, government contracts activity, expansion of the medical adviser system on claim decisions, and comments on the 1973-75 Insurance Department Audit final report, copy of which was provided to Council members.

B. Reports to State of Wisconsin Group Insurance Board

The Council reviewed and acted upon proposed reports to the Group Insurance Board as called for in a supplement to the group master contract:

(1) Second Opinion for Elective Surgery

On motion of Doctors Waterhouse-Smejkal, carried, the Council approved the "Analysis of Second Opinion Benefit Programs for Elective Surgery" for transmittal to the Board.

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Also presented was a prototype for a second opinion program, and the question of the Council was whether it approved WPS having such a benefit within its portfolio, allowing group subscribers to elect its use. It was pointed out that the Motors account is developing its own limited approach to presurgical screening. This approval was included in the above motion.

(2) Usual, Customary and Reasonable Fees

On motion of Doctors Waterhouse-Mullooly, carried, the Council accepted the report on history, administration and results of UCR fees for forwarding to the Board.

(3) Health Maintenance Program

On motion of Doctors Waterhouse-Mullooly, carried, the Council approved transmittal of the report on history and administration of HMP.

Doctor Waterhouse, as chairman of the WPS Commission Claims Committee, raised a question on interpretation of 1976 action by the House of Delegates in reference to allowable fee increases following the lifting of the freeze effective May 1, 1976.

A review of the action showed that:

(1) The earliest allowable date of increase following the freeze, providing the request was received by WPS 120 days in advance of April, would be effective May 1, 1976.
(2) "Future fee screen level changes will be accepted by WPS no more often than on an annual basis."

Consequently, for those whose 1976 increase was on May 1, no further increase would be effective before May 1, 1977.

15. Commission on Health Facilities and Services

Doctor Parker discussed recommendations of the commission directed at a program of increasing physician influence in the health planning process.

On motion of Doctors Williams-Smejkal, carried, the Council supported the concept of county medical societies forming regional advisory committees to the physician members of HSA boards, the details to be worked out with Society staff.

On motion of Doctors Mullooly-Waterhouse, carried, the Council approved the further recommendation that specialty sections be charged with providing advice and data through staff on specific health planning issues when there is a request by a regional advisory group or a physician member of an HSA board.

16. Ad Hoc Committee on Chiropractic

Doctor Williams reported the pending status of the Society's appeal for hearings to be held on revisions in the administrative code relative to the practice of chiropractic. The committee has also discussed procedures for physicians under the nursing home bill of rights, and it was noted that the governor may be proposing that all treatment within nursing homes under Medicaid must be ordered by a physician. The committee will attempt to introduce legislation this year reversing prior action with regard to payment of chiropractors for Medical Assistance, Workmen's Compensation, and health insurance.

On motion of Doctors Foley-Smejkal, carried, the report was accepted.

17. Report of AMA Delegation

Doctor Twelmeyer limited his report to AMA House of Delegates actions on national health insurance and on direct billing of AMA dues, the latter to be reviewed again in 1977.

18. Amphetamines under Medicaid

The Council received a copy of President Picard's response to Mr Carballo objecting to the requirement of prior authorization for reimbursement of amphetamine products under Medicaid and suggesting referral to the Controlled Substances Board for development of a formal drug utilization review program.

19. Report of the Secretary

This was received for information.

20. New Business

Doctor Derus recommended that an early explanation be communicated to the membership on why SMS dues are the highest in the country, according to a recent listing in *Medical Economics*.

21. Adjournment

The meeting adjourned at 5:30 pm.

EARL R THAYER
Secretary

Approved: March 5, 1977
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MEMBERSHIP REPORT

his listing appears as a newsworthy feature nd is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership eportment.

Membership Report s of February 18, 1977

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

ounty Medical Society

ANE

arter, William L, 453 N Baldwin St, Madison 53703 (1937, Resident, Plastic Surgery)
leschievitz, Carlton, 34A University Houses, Madison 53705 (1947, Resident, Public Health)

ODGE

anke, Richard W, Rt 1, Flyway Medical Clinic, Horicon 53032 (1946, Regular, Family Practice, Certified)
istl, Robert N, Rt 1, Box 96A, Horicon 53032 (1945, Regular, Family Practice, Certified)

EAU CLAIRE-DUNN-PEPIN

Kaufman, Stuart D, 334 Garfield Ave, Eau Claire 54701 (1946, Regular, General Practice)
Walker, James A, 2211 Stout Rd, Menomonie 54751 (1948, Regular, Internal Medicine)

MANITOWOC

Goswitz, John T, 601 N 8th St, Manitowoc 54220 (1933, Regular, General Surgery, Certified)

MARATHON

Drake, Ellet H, A Ward Ford Memorial Institute, Ridgeway Bldg, Maple Hill, Wausau 54401 (1914, Regular, Pediatrics)

MILWAUKEE

Brown, John Robert, 5621 Broad St, Greendale 53129 (1942, Regular, General Surgery, Certified)
Cody, Edward F, 610 N 19th St, Milwaukee 53233 (1949, Resident, Family Practice)
Dolan, James D, 5000 W Chambers St, Milwaukee 53210 (1950, Resident, Obstetrics and Gynecology)
Duquesnoy, Rudolf, 2388 N Lake Dr, Milwaukee 53211 (1947, Regular, Pediatrics)
Solanki, Kirit V, 2900 W Oklahoma Ave, Milwaukee 53215 (1944, Regular, Pathology)
Spellman, Robert J, 720 E Wisconsin Ave, Milwaukee 53202 (1948, Regular Internal Medicine)
Walsh, John P, 2500 N Mayfair Rd, Milwaukee 53226 (1941, Regular, Urological Surgery)

WAUKESHA

Imse, David P, 1308 E Devonshire Rd, Delafield 53018 (1947, Regular, Family Practice)
Iorio, Kathryn D, 1111 Delafield St, Waukesha 53186 (1941, Regular, Pediatrics)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DANE

Richards, Marcis J S, Madison, to 2315 North Lake Dr, Milwaukee 53211

MILWAUKEE

Kassowitz, Karl E, Milwaukee, to 1755 View Point Rd, Boulder, CO 80303
Rhee, Yong H, Glendale, to 2003 West Capitol Dr, Milwaukee 53206

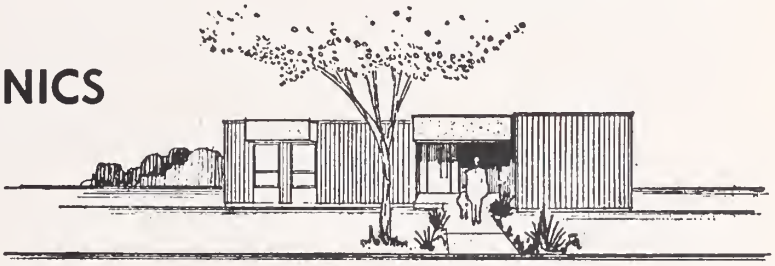
OUTAGAMIE

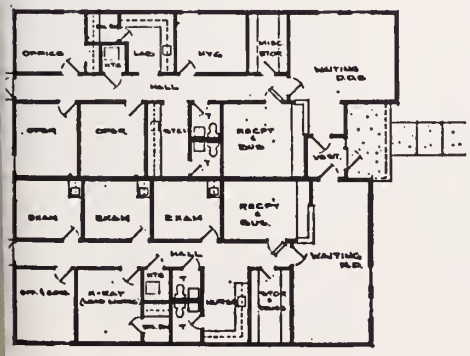
Malueg, Thomas J, Neenah, to 3747 Lane Lake Dr, Bloomfield Hills, MI 48013
Taake, E Robert, Appleton, to Theda Clark Memorial Hospital, Neenah 54956
Zimmerman, Deland E, Appleton, to 231 Nuttingham Dr, Springfield, IL 62704

DEATHS

Millington, Paul E, Milwaukee County, June 13, 1976
Hebenstreit, A J, Dodge County, Jan 15, 1977
DeCock, Robert D, Outagamie County, Jan 24, 1977

MEDICAL & DENTAL CLINICS





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Membership Report as of February 28, 1977

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

BROWN

Koch, Paul D, 3090 Pine Ridge Court, Green Bay 54301 (1943, Regular, Internal Medicine, Certified)

GREEN

Kindschi, George W, 2639 Hillcrest Court, Monroe 53566 (1940, Regular, Pathology, Certified)
Nemovitz, Paul M, 1515 10th St, Monroe 53566 (1946, Regular, Internal Medicine, Certified)
Paull, Laurence G, 515 22nd Ave, Monroe 53566 (1949, Regular, Radiology/Diagnostic Radiology, Certified-R)
Vincent, Robert A, 515 22nd Ave, Monroe 53566 (1944, Regular, Diagnostic Radiology, Certified-R)

PIERCE-ST. CROIX

Gwin, John F, 226 Locust St, Hudson 54016 (1944, Regular, Pediatrics)
Larson, E Arthur, PO Box 99, New Richmond 54017 (1932, Regular, Psychiatry, Certified)

RACINE

Firling, Randall J, 1310 College Ave, Racine 53403 (1947, Regular, Psychiatry)
Irani, Sohrab R, 325 E Jefferson St, Burlington 53105 (1944, Regular, Obstetrics and Gynecology)

RICHLAND

Wisniewski, Gerald R, 1289 W Seminary St, Richland Center 53581 (1946, Regular, Internal Medicine, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DODGE

Chung, Woo Young, Beaver Dam, to 3201 South 16th St, Milwaukee 53215

MILWAUKEE

Kehlnhofer, F H, Wauwatosa, to 2037 Underwood Ave, Milwaukee 53213
Stanhope, C Robert, Glenview, IL, t 7802 Gulfton, Houston, TX 77036

OUTAGAMIE

Landis, Ralph V, Appleton, to 235 North Lake Dr, Milwaukee 53211

ROCK

Miller, David, Beloit, to Western Ele tric, Gateway 11, Newark, NJ 071

COUNTY-TO-COUNTY TRANSFER

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Dane to Jefferson: Banning, Richard I Rte 2, Boje Lane, Watertown 5309
Green to Eau Claire-Dunn-Pepin: Kat David J, 900 W Clairemont Ave, Ea Claire 54701

DEATHS

Vogel, Thorn L, Rock County, Feb 1977
Barr, Arnold H, Ozaukee County, Ja 14, 1977

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OBITUARIES

◈ County, State, AMA Members

◈ **Paul E Millington, MD,** 79, Elm Grove, died June 13, 1976 in Salem, Ark. Born on May 29, 1897 in Waverly, Iowa, Doctor Millington graduated from Marquette University School of Medicine in 1944. Surviving is his widow, Annabelle, Horseshoe Bend, Ark.

◈ **Gerald Edward Bourget, MD,** 60, Hudson physician from 1950-1975, died Jan 2, 1977 in Eau Claire. Born Oct 15, 1916 in Cadott, Doctor Bourget graduated from the University of Minnesota Medical School in 1944. He was elected first chief of the medical staff of the Hudson Memorial Hospital in 1964. Surviving are his widow, Mary; two sons, Philip, Plymouth; Paul, Madison; and three daughters, Ann, San Francisco, Calif; Jeanne, Milwaukee; and Helene, Eau Claire.

◈ **Arnold Henry Barr, MD,** 75, Port Washington, died Jan 14, 1977 in Port Washington. Born Dec 15, 1901 in Chicago, Ill, Doctor Barr graduated from Indiana University Medical School in 1926. He served as a member of the board of directors of Blue Cross of Wisconsin for 18 years, served as the State Medical Society's chairman of the Committee on Hospital Relations and also served on the executive council for Alcohol and Drugs of the National Safety Council.

Surviving are his widow, Jeanette; two children, Robert J, Sheboygan; Elizabeth Bylaska, Sturgeon Bay; and a sister, Mrs Edna Wright of Paw Paw, Mich.

◈ **Roland H Frederick, MD,** 82, West Allis physician for 44 years, died Jan 15, 1977 in West Allis. Born Ap 30, 1894 in Milwaukee, Doctor Fred rick graduated from Marquette Unive sity School of Medicine in 1923. H served as an alternate delegate from th Medical Society of Milwaukee County the House of Delgates of the State Me ical Society of Wisconsin from 195 1969. Surviving are three sons, Roland Waukesha; Tom, Barrrington, Ill; Jerr Wauwatosa; and two daughters, M Mary Gableman, New Berlin; and M Kathleen Reader, Delavan.

◈ **Austin Joseph Hebenstreit, MI** 81, a physician at Wisconsin State Priso Waupun, for 21 years, died Jan 15, 197 in Juneau. Born Jan 29, 1895 in Shull berg, Doctor Hebenstreit graduated fro Creighton University, Omaha, Nebrask in 1920. Surviving are three sons, Wi liam, Milwaukee; Andrew, Waupu and Thomas, Indianapolis, Ind.

◈ **Thomas Francis McCormic MD,** 88, Milwaukee, died Jan 27, 197 in Milwaukee. Born Nov 17, 1888 Milwaukee, Doctor McCormick grad ated from Marquette University Scho of Medicine in 1916. Doctor McCormi practiced in Milwaukee for 50 years b fore retiring in 1970. Surviving are fo children, Mrs Robert (Mary Pat) Cu ningham, Milwaukee; Mrs John (Kat leen Ann) Scanlan, Closter, NJ; Mrs Br an (Monica) McLaughlin, Bayside; ar Mrs Robert (Nancy) Rambusch, Ne York.

◈ **Arnold J Marx, MD,** 44, Mad son, died Feb 14, 1977 in Madison. Bo on Aug 27, 1932 in Newark, Ne Jersey, Doctor Marx graduated fro the Chicago Medical School in 196 Surviving are his widow, Bonnie; ar three children, David, Todd, and Jessic

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CeeNU is especially effective against CNS tumors, Hodgkin's disease, and lung cancer; has fair activity against non-Hodgkin's lymphoma and malignant melanoma; and, at this time, is less active against colon, breast, renal cell, and head and neck cancer.

It can be used effectively in a multiple drug protocol with procarbazine and vincristine, commonly called PCV, against malignant gliomas, medulloblastomas, glioblastoma multiforme, anaplastic astrocytoma, and grade III-IV astrocytomas. It is effective for palliation of brain metastases.

The most common side effects are nausea, vomiting, thrombocytopenia, and leukopenia. It can also cause stomatitis, alopecia, anemia, hepatic toxicity, disorientation, lethargy, ataxia, and dysarthria. It should not be given to individuals who are hypersensitive to it. Its safe use in pregnancy has not been established, but it is embryotoxic, teratogenic, and carcinogenic in animals.

CeeNU should only be administered by those experienced in the use of antineoplastic therapy. Blood counts should be monitored weekly for at least six weeks after treatment. Liver function should be monitored periodically.

The recommended dose of CeeNU in adults and children is 130 mg/M^2 as a single dose orally every six weeks. It is available from Bristol Laboratories in 10, 40, and 100 mg capsules which can be stored at room temperature for at least two years.—DOROTHY J BUCHANAN-DAVIDSON, PhD, Science Writer, WCCC

Dial Access System

The Dial Access System of the University of Texas System Cancer Center, MD Anderson Hospital and Tumor Institute in Houston, Texas, is available to physicians. It contains more than 300 six to eight minute tape recordings covering the most recent diagnostic and therapeutic information of specific neoplastic disease problems. These were listed in a pamphlet physicians received in January. The tapes can be heard by dialing the toll-free number, 1-800-231-6970, and giving the operator your name, profession, address, and number of the tape you would like to hear.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

Head and Neck Cancer

The last of the Head and Neck Cancer Regional Conferences will be held May 4 in Madison, in the morning at Union South and in the afternoon at the ENT Outpatient Clinic at University Hospitals. For more information contact the Wisconsin Division of the American Cancer Society, Inc, 611 North Sherman Avenue, Madison, telephone 1-608-249-0487.

Immunotherapy of Solid Tumors

The 1977 Chicago Symposium on Immunotherapy of Solid Tumors was held in Chicago, February 24-25. There were some interesting results, but poor responses were reported in the immunotherapy of many cancers. Because the field is new, there are many flaws in the design of the tests—too many variables, too few patients, no controls, use of historical controls, lack of standardization of materials tested, and the like. Much of the work has been done on patients with advanced cancer, yet the best results are being achieved in patients with a small tumor burden.

Intrapleural BCG in patients with surgically resected lung cancer helped. Direct injection of BCG into lung cancers was more effective when there was intact host immune responsiveness. BCG puncture or scarification techniques weren't very effective.

Treatment of urogenital cancer with *Corynebacterium parvum* didn't improve survival. CAMF (cyclophosphamide, adriamycin, methotrexate, 5-fluorouracil) and *C. parvum* had a slight effect on breast cancer. *C. parvum* caused moderate toxicity yet didn't reduce the bone marrow suppressive effects of chemotherapy.

When surgically resected stage I lung cancer patients were treated with specific soluble antigen in Freund's complete adjuvant, the disease-free interval was increased.

Breast cancer patients treated with CMF (cyclophosphamide, methotrexate, 5-fluorouracil) plus BCG or CMF plus BCG plus irradiated allogeneic tumor cell vaccine survived longer. Patients with local recurrence following radiation therapy responded to intratumor BCG injection.

Sarcoma patients treated with vincristine, cyclophosphamide, adriamycin, and/or actinomycin D and DTIC (Imidazole carboxamide dimethyl triazeno), and intracutaneous BCG and sarcoma viral oncolysates showed less tumor progression than patients treated by chemotherapy alone.

Encouraging results were observed when neuraminidase-treated autologous tumor and BCG were given with methotrexate plus leucovorin rescue to patients with head and neck cancer.

Immunologic tests didn't correlate with the patient's clinical response usually. A method for measuring the appearance of circulating cancer cells which was followed by cancer recurrence in the skin and viscera was described.—DOROTHY J BUCHANAN-DAVIDSON, PhD, Science Writer, WCCC

NEWS HIGHLIGHTS

Marquette-MCW Medical

. . . Alumni Association will hold its annual banquet May 27 at the Performing Arts Center. The banquet will be followed by the Tony Bennett Benefit Concert. The following graduating classes will hold reunions at the time of the banquet: 1967, 1962, 1957, 1952, 1947, 1942, 1937, 1932, and 1927. Special recognition will be given to the class of 1952, whose members will be celebrating their silver jubilee.

Thomas C Puchner, MD,* class of 1946, will be installed as president of the alumni association, succeeding Robert F Purtell Jr, MD,* class of 1961. New officers will be elected and the alumni will also honor the "1977 Alumnus of the Year," Derward Lepley Jr, MD,* Milwaukee heart surgeon.

The Marquette-MCW Medical Alumni Association and the Medical College of Wisconsin will cosponsor receptions for alumni, faculty, and friends at four national specialty society meetings during 1977. The first scheduled reception will be held April 20 at the Fairmont Hotel in Dallas, Tex during the annual meeting of the American College of Physicians. Receptions also will be held May 11 in Chicago during the annual meeting of the American College of Obstetricians and Gynecologists; October 10 in Las Vegas during the annual meeting of the American Academy of Family Physicians; and October 19 in Dallas during the American College of Surgeons annual meeting.

Eye Institute

. . . of the Medical College of Wisconsin and Milwaukee County Medical Complex, Milwaukee, which officially opened in December 1976, will dedicate its new building as a major, new scientific facility, June 2-4. Ophthalmologists from throughout the nation and abroad will assemble for a meeting on the most significant advances in the field. Guest faculty will include ophthalmologists who direct programs at most of the nation's other leading eye centers. The Eye Institute is an eight-story building connected to Milwaukee County General Hospital and houses the department of ophthalmology for the college and the hospital. It consolidates patient care and educational activities previously located in the hospital and provides space to greatly expand research programs.

Tony Bennett Benefit Concert

. . . is the second annual event sponsored by the Medical College of Wisconsin's faculty assembly, the Marquette-MCW Medical Alumni Association and Auxiliary, to be held May 27 at the Performing Arts Center in Milwaukee. Proceeds from the concert are used for the student aid program which provides long-term low interest loans to medical students on the basis of need. Nearly 58 percent of MCW students receive some form of financial assistance since the costs of medical education including living expenses average $7,500 a year or $30,000 for four years of study. Last year's Ella Fitzgerald concert raised $27,000 for student aid. The funds were used to directly aid 97 students. MDs John R Litzow* and Edward Stewart* are members of the benefit committee.

Wisconsin Lung Association

. . . on April 22 will be presenting a daylong discussion of "Smoking and Health" at the Pfister Hotel in Milwaukee. State Medical Society members who will address the audience are MDs Larry A. Lindesmith,* president of the WLA, LaCrosse; and Louis C Bernhardt,* Dean Clinic, Madison. The program precedes the Annual Meeting of the WLA and the Wisconsin Thoracic Society, April 23.

Medical College of Wisconsin

. . . recently approved funds for the construction of a specially designed laboratory to conduct recombinant DNA research, the study of genetic control mechanisms. The laboratory is to be located in the new medical education building on Milwaukee County Institutions grounds and is scheduled for completion in the fall of 1978. Bruce Moholt, PhD, assistant professor of microbiology and surgery, will be the laboratory's new director. ■

PHYSICIAN BRIEFS

Fred J Ansfield, MD*

. . . Madison, retired from the Department of Human Oncology, University Hospitals, has joined MDs Gerald J Kallas* and Juanito P Singson* in private practice at St Mary's Community Cancer Center in Milwaukee.

Maurice G Rice, MD*

. . . founder of the Rice Clinic, Stevens Point, recently was honored by the Rice Clinic with a plaque and a medical education fund named for him. Doctor Rice was with the Rice Clinic until January 1974 when he moved to Madison and became employed part-time as a medical adviser by the Social Security Administration. Doctor Rice graduated from Marquette University Medical School and began practice in Stevens Point in 1934. The Clinic was founded in 1952.

Michael W Bachhuber, MD*

. . . Mayville, recently accepted the Wisconsin Association of Soil and Water Conservation District's 1976 award for Wildlife Habitat Development. Doctor Bachhuber has worked on his 213-acre farm since 1973 and the entire farm has been used as a study and tour area for college level agricultural students under the Keys Seminar Program. Doctor Bachhuber plans to retire on his farm after medical practice.

Eleanor Delfs, MD*

. . . professor of gynecology and obstetrics, Medical College of Wisconsin, Milwaukee, will be receiving the Distinguished Service Award at MCW Commencement exercises, May 29. A graduate of Johns Hopkins University School of Medicine in 1935, Doctor Delfs completed postgraduate work at Hopkins and then joined its faculty in 1939. She became an associate professor of obstetrics in 1950. In 1963 she joined the Medical College as a full professor. Her pioneering work designed to monitor patients who have trophoblastic tumors of the uterus is considered one of the major contributions during the past century in the field of gynecological oncology.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Douglas Madlin, MD

. . . Port Washington, recently became associated with the Port Washington Clinic. A 1973 graduate of Duke University Medical School, Durham, NC, he completed his internship in internal medicine at the University of Tennessee, Memphis, in conjunction with the City of Memphis hospitals.

Paul A Capelli, MD*

. . . obstetrician and gynecologist, has been elected president of the medical staff of St Catherine's Hospital, Kenosha. Other physicians elected are MDs Vincent P Savaglio,* Kenosha, vice-president and president-elect; A James Bennett,* Kenosha, secretary; and executive committee members are Andrew T Przlomski,* Raymond W Witt,* and Glenn E Vandervort* of Kenosha.

George A Hellmuth, MD†

. . . and Phillip J Hellmuth, Milwaukee, have published a book entitled, "Prevention of Heart Attack: A Challenge to the Health Professions." Publication was sponsored by the Department of Physiology, Medical College of Wisconsin, Milwaukee. The book focuses on ways in which the allied health professions can reach and educate the public on the prevention of coronary heart disease. Doctor Hellmuth, late professor of physiology at the MCW and director of Heart Rehabilitation Center, Curative Workshop of Milwaukee and MCW, was awarded posthumously the "Outstanding Physician" plaque by the Wisconsin Heart Association in 1974. Mr Hellmuth is assistant dean and director of research and personnel services at the College of Letters and Science, University of Wisconsin-Madison. At the request of the authors, the State Medical Society was given a copy for its Library.

Derward Lepley Jr, MD*

. . . clinical professor of thoracic and cardiovascular surgery, Medical College of Wisconsin, Milwaukee, will be receiving the Distinguished Service Award at MCW Commencement exercises, May 29. A 1949 alumnus, Doctor Lepley is perhaps best known for leading the surgical team that performed the heart transplant on Mrs. Betty Anick,† currently the longest such surviving patient. Doctor Lepley began his early research while serving his thoracic surgery residency at Wood Veterans Administration Hospital in Milwaukee. After completing a two-year research fellowship from the National Heart Institute he joined the Marquette University School of Medicine in 1956. He has served full and part-time positions as professor and chairman of thoracic and cardiovascular surgery. He considers the academic programs established for heart and chest surgeons at the Medical College his greatest contribution to medicine. He is one of the pioneers of hypothermia, the method of cooling the total body during the time the patient is on the heart-lung machine. He also is one of the early pioneers of artificial valve surgery. In 1972 he performed the first operation for correction of the "Uganda heart" by removing the entire lining of the left ventrical and replacing the mitral valve with an artificial valve. It is considered a surgical first. The affliction, a scarring of the left ventrical, affects people in the equatorial part of the world and all die within two years of the onset of the symptoms. Following surgery the patient is completely healthy and free of symptoms. †Deceased March 22, 1977

Richard D Stewart, MD*

. . . professor and chairman of environmental medicine, Medical College of Wisconsin, passed the examination for certification by the American Board of Medical Toxicology held recently in Seattle, Wash. Doctor Stewart is a diplomat of the American Board of Internal Medicine.

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Anthony R Curreri, MD

. . . Madison, recently received the Department of Defense's highest civilian award, the Distinguished Public Service Award, for his work as president of the Uniformed Services University of Health Sciences in Washington DC. A former associate vice-chancellor for health sciences at the University of Wisconsin-Madison Health Sciences Center, he became the first president of the military medical school in 1974. He returned to the University of Wisconsin, Madison in November 1976 as professor of surgery. Doctor Curreri also is an associate chief of staff for education at the Veterans Administration Hospital in Madison.

Gerry Geroso, MD

. . . Two Rivers, recently joined the medical staff of Doctors Clinic in family practice. For 10 years he was associated with the Kauai Medical Group Inc in Lihue, Hawaii. Doctor Geroso is currently president of the Kauai Medical Society, and assistant professor of family practice at the University of Hawaii College of Medicine. He is board certified and served family practice residencies at South Shore Hospital, Chicago, and Elyria Memorial Hospital, Elyria, Ohio.

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James C Hanley, MD

. . . Burlington, recently became associated with the Burlington Clinic in the practice of obstetrics and gynecology. Doctor Hanley, a graduate of the University of Illinois Medical School, previously practiced for four years in Pekin, Ill.

Robert F Wichser, MD*

. . . Monroe, has been named president of St Clare Hospital's medical staff for 1977. He succeeds David C Riese, MD.* Other MDs elected are: Harold H Scudamore,* president-elect; Ross L Cline,* secretary; Jack F Murray* and James R Stormont,* members-at-large.

Edward A Bachhuber, MD*

. . . professor of surgery at the Medical College of Wisconsin, Milwaukee, will be receiving the Distinguished Service Award at MCW Commencement exercises, May 29. A native of Wisconsin, Doctor Bachhuber currently is president of the Milwaukee Academy of Surgery. After receiving his MD degree from Harvard Medical University in 1937, he completed his internship and residency in surgery at Milwaukee County General Hospital. In 1946 he joined the staff of Marquette University School of Medicine (now MCW). He established the first structured clinical teaching program at the College and continued to formalize the early surgical training for medical students and physician trainees. In addition to his teaching duties he served as associate dean from 1956-1965 and as chairman of the administrative committee charged with the dean's responsibilities from 1963-1964.

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William H Nicolaus, MD*

. . . former Green Bay anesthesiologist, recently was assigned as the senior medical officer to the Naval School of Diving and Salvage, Washington DC, following completion of the Undersea Medical Officer program, Naval Undersea Medical Institute, New London, Conn. Presently Cdr Nicolaus is a staff member of the Department of Hyperbaric Medicine and Physiology at the Naval Medical Research Institute, Bethesda, Md.

Charles J Finn, MD*

. . . Wauwatosa, president of the medical staff of Deaconess Hospital, recently was elected to a three-year term on the Deaconess Hospital board of directors. An otolaryngologist, Doctor Finn is a graduate of the University of Wisconsin Medical School in Madison.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MARCH 1977

1 Dane County Medical Society Board of Trustees
2 WisPRO Review and Evaluation Committee
3 State Auxiliary Finance Committee
3 Task Force on Health Screening and Immunization
3 Madison Radiology Society
5 SMS Council
7 Planning for Wisconsin Work Week of Health—1977
8 WisPRO-FMCE Long Term Care Committee
9 SMS Commission on Peer Review
9 SMS Committee on Federal Legislation
9 SMS Commission on Governmental Affairs
14 Madison Orthopedic Society
14 Dane County Medical Society Insurance Advisory Committee
15 Madison Society of OB-GYN
16 WisPRO Executive Committee and Board of Control
16 T19 Provider Agreement
21 Dane County HMP Committee
25 SMS Physicians Alliance Commission
25 SMS Medical Defense Committee
26 Executive and Legislative Committees, Section on Ophthalmology
27 2nd Councilor District Caucus
29 State Steering Committee on H24
29 SMS Committee on Safe Transportation
31 Preceptors and Faculty, University of Wisconsin Medical School

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parentheses.

Mischa J Lustok, MD*

. . . Shorewood, has received the 1976 Dr Max Fox Preceptorship Award of the University of Wisconsin Medical Alumni Association. Doctor Lustok is a 1935 graduate of the University of Wisconsin Medical School, editor of the *Wisconsin Medical Alumni Quarterly*, and has been an officer and active member of the medical alumni association for more than 20 years. He was appointed a preceptor in 1966.

Timothy K Henke, MD*

. . . LaCrosse neurologist associated with the Gundersen Clinic, Ltd since 1969, recently became neurologic consultant to the Wisconsin Social Security Disability Insurance Bureau, Madison. A graduate from the University of Wisconsin Medical School, Madison, Doctor Henke served his internship at Rhode Island Hospital, Providence, and his residency in neurology at the University of Wisconsin Medical Center.

Orlando M Francisco, MD*

. . . president of the medical staff of Sacred Heart Hospital, Tomahawk, recently was recertified by the American Academy of Family Physicians. He became board certified in 1970 and is recertified until 1982.

Yen J Fuh, MD*

. . . clinical assistant professor of medicine of the Medical College of Wisconsin, recently was appointed as medical director of Respiratory Therapy at Community Memorial Hospital, Menomonee Falls. Doctor Fuh has opened his private practice in Internal Medicine and Pulmonary Disease at Wauwatosa.

Paul F Wagner, MD*

. . . Brookfield, recently opened his medical practice in Burlington. An eye physician and surgeon, Doctor Wagner graduated from the University of Wisconsin, Madison, and served his internship at Hennepin County General Hospital, Minneapolis, Minn. His ophthalmology residency was taken at University Hospitals in Madison. Prior to moving to Burlington, he had been in private practice in Brookfield for two years.

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An award-winning photograph

John E Ridley III, MD*

. . . Mequon ophthalmologist, was one of eight physicians among the top 800 winners in the 1976 Kodak International Newspaper Snapshot Awards (KINSA) which attracted more than 325,000 entries. Sponsored by Eastman Kodak Company, the competition was conducted by 109 newspapers in the United States, Mexico, and Canada which held summer photography contests.

Doctor Ridley was experimenting with electronic flash when he photographed his daughter, Lisa, sitting in the doorway of a darkened room. "I put a sheet of typing paper over the flash," says Doctor Ridley, "and then printed the photograph through a piece of glass lightly smeared with petroleum jelly." KINSA judges liked the result: Doctor Ridley won a $100 special merit award.

The Kodak awards program has been conducted annually since 1935. It's channeled through participating newspapers' summer photography contests which start in mid-May. Anyone wishing to enter KINSA in 1977 and not knowing a participating newspaper can write for details to Contest Activities Section, Corporate Information Department, Eastman Kodak Company, Rochester, NY 14650.

Derward Lepley Jr, MD*

. . . internationally known heart surgeon of the Medical College of Wisconsin, Milwaukee, has been named Marquette University's 1977 Alumnus of the Year. A 1949 alumnus of the then Marquette School of Medicine, Doctor Lepley received the award at a formal alumni reception and dinner, April 2, at Milwaukee's Performing Arts Center. Doctor Lepley's most public achievement came in October 1968 when he headed a 15-man team at St Luke's Hospital, Milwaukee, in performing a heart transplant for Mrs Betty Anick.† The West Allis woman has survived longer than any other person with a heart transplant. The author or co-author of more than 80 scientific publications, Doctor Lepley has done considerable pioneering research and surgery in the area of children's heart disease. His other major area of concentration is the implanting of artificial heart valves. He himself underwent coronary bypass surgery in 1975. †Deceased March 22, 1977

Robert C Kaupie, MD*
Darrell L Witt, MD*

. . . Wausau, recently were certified by the American Board of Family Practice. Doctor Kaupie graduated from the University of Wisconsin Medical School, Madison, and served his internship at Good Samaritan Hospital, Phoenix, Ariz. Doctor Witt graduated from the University of Iowa Medical School and served his internship at Hurley Hospital, Flint, Mich. Both physicians are members of the medical staff of the Wausau Medical Center.

Fredric A Steiger, MD*

. . . has been appointed assistant professor of psychiatry and mental health sciences at the Medical College of Wisconsin, Milwaukee. He is based at the Child and Adolescent Treatment Center. Doctor Steiger joined the Medical College after completing a residency in child psychiatry at the MCW-affiliated Milwaukee Children's Hospital. A rotating internship and psychiatry residency were served at Northwestern University School of Medicine where he received his MD degree in 1971.

Mahendra Kochar, MD*

. . . assistant professor of medicine and pharmacology, Medical College of Wisconsin, Milwaukee, is listed in the 14th volume of the *Dictionary of International Biography* in recognition of his efforts in hypertension control as director of the Milwaukee Blood Pressure Program. The book is published by the International Biographical Center, Cambridge, England.

M A M Al Batata, MD*

. . . assistant professor of pathology, Medical College of Wisconsin, Milwaukee, has been elected a member of the editorial review board of the Group for Research in Pathology Education, San Antonio, Tex.

Jack C Westman, MD*

University of Wisconsin-Madison psychiatry professor, is the new president-elect of the American Association of Psychiatric Services for Children. This association represents 10,000 professionals delivering mental health services to children, adolescents, and their families.

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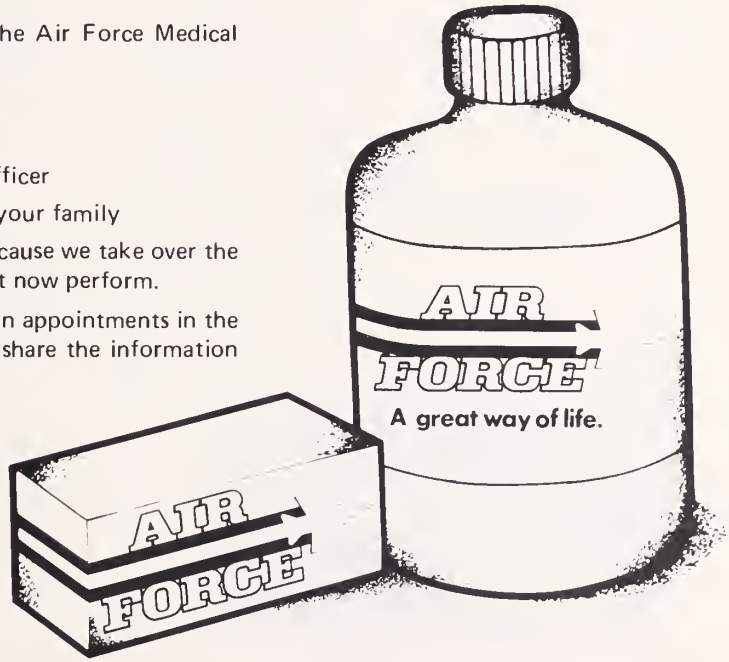

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Herzl Spiro, MD

. . . Whitefish Bay, recently was elected chairman of the mental health section of the American Public Health Association. Doctor Spiro is professor and chairman of the department of psychiatry and mental health sciences at the Medical College of Wisconsin. He also is director of psychiatry for the Milwaukee County institutions and departments and is president of the medical staff for Milwaukee Psychiatric Hospital.

Joseph C Darin, MD*

. . . Professor of Surgery, Medical College of Wisconsin, Milwaukee, has been named recipient of the 1976 American College of Surgeons' Trauma Achievement Award. The award, presented March 18 at the ACS Committee on Trauma's annual meeting in Anaheim, Calif, came in recognition of Doctor Darin's outstanding achievements in the field of trauma and for his organization of the Northeastern Wisconsin Committee on Trauma.

Mark J Cinccantelli, MD*

. . . has been appointed associate professor of family practice at the Medical College of Wisconsin, Milwaukee. He is based at Deaconess Hospital, the headquarters of MCW's family practice program. Doctor Cinccantelli has both academic and private practice experience. He has been on the clinical faculty at the Medical College since 1954 serving as instructor, assistant professor and associate professor in the department of medicine. His private practice has been in LaCrosse and Milwaukee.

Thorn L Vogel, MD†

. . . who died February 9 in Janesville, last fall published a book, "Woebegone," which he had written while convalescing from a cerebrovascular accident. He had kept a diary of his 31 years of private practice in Janesville where he also was employed as health commissioner. Doctor Vogel's book, written in story form, contains humor, pathos, tragedy, exultation, depression, and many features not usually encountered in general practice. An active member in the State Medical Society during his years of practice, Doctor Vogel served as president of the Wisconsin Public Health Physicians for two years. Doctor Vogel's book was two years in the making and was entirely done in longhand. Before his death Doctor Vogel sent a copy to the State Medical Society; it has been placed in the Library.

Cassandra Van Nostrand, MD

. . . pediatrician, has been associated with the Grantsburg Clinic, Ltd for the past several months. Doctor Van Nostrand is continuing her education at the University of Minnesota and is only working at the Clinic part-time. A native of Canada, she graduated from the University of Alberta School of Medicine, Edmonton, Alberta in 1972, and served residencies at Johns Hopkins University, Baltimore, Md, University of Virginia, Charlottesville, Va, and the University of Minnesota. ■

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Drug substitution In most states, pharmacy laws, gulations or professional custom stipulate that your n-generic prescriptions be filled with the precise prod- s you prescribe. But in the last five years, a dozen or re State laws have been changed, permitting the phar- cist in most cases to select a product of the same neric drug to fill any prescription.

Ironically, this dilution of physician control has en place against a background of growing evidence t purportedly equivalent drug products may be in- ivalent, since neither present drug standards nor their forcement are optimal. In fact, the FDA itself says it not enforced the same standards for hundreds of llow-on" products that it had applied to the original DA approvals. Thus physician control over patient rapy is being eroded with a risk that patients may be osed to drugs of uncertain quality.

The major advertised claim for substitution is reduced scription prices for consumers. Yet no documentation any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is ederal regulation designed to cut the Government's g bill by setting price ceilings for drugs dispensed to dicare and Medicaid patients. Unless the prescriber tifies on the prescription that a particular product is dically necessary, the Government intends to pay only the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

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American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS APRIL 1977

"Climb Every Mountain"

THE THEME of the 22nd Annual Meeting of the American Association of Medical Assistants, Inc, Wisconsin Society, May 20-22, 1977 at Alpine Valley Resort, East Troy, Wisconsin, is "Climb Every Mountain" from the "Sound of Music" score. And it's quite appropriate. The organization, at all levels of membership, is dedicated to increasing the professionalism of medical assistants through excellent continuing education programs incorporated into its meetings.

The Rock Chapter will host the three-day state convention which will open at noon Friday with a luncheon for delegates and the Executive Board. The House of Delegates will then convene at 1:15 pm. Following this session, the Rock Chapter has planned a barbecue social. The Band Aid, a group of medical assistants from Beloit Clinic, will provide entertainment with some novelty singing.

The educational part of the program on Saturday will feature several speakers. Melanie G Ramey, JD of Madison, will focus on the subject of "Family Violence." Miss Ramey is a social worker and conducts her own business—Educational Video.

Dr Dean Miller, PhD of Incline Village, Nevada, is the National Chairman of the Physical Fitness Program and was instrumental in designing the astronaut fitness program. Quite naturally, his topic will center on "Physical Fitness."

Dean Vaughn of Pittsburgh, Pennsylvania, who conducts a medical training system in that city, will present the topic—"Speed Course in Anatomy."

Another speaker, unnamed at press time, will enlighten the group on "How to Show Love to Patients."

The Presidents' Luncheon will honor all past State Presidents and current Chapter Presidents. Awards will be given to the winner of the Publications Contest and to the Chapter having the greatest percentage of membership increase.

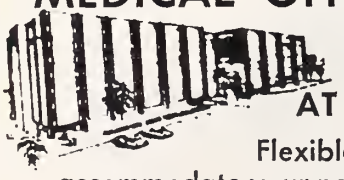
Entertainment for Saturday night festivities will be provided by the Sign Song Dancers from the Wisconsin School of the Deaf in Delevan. They will perform a "sign interpretation" routine. The evening will be climaxed by the Installation of Officers. Mrs Dolores J Conlon will be installed as president. Her fellow Milwaukee Chapter members will be hostesses for a post-installation reception.

The Sunday morning brunch will conclude the 22nd Annual Meeting with announcements of committee appointments and a summary of the House of Delegates proceedings.

Further information regarding the Convention may be obtained by contacting Patricia Harper, 514 Locust Street, Beloit, WI 53511. Telephone: 608-362-1398 (Home) or 608-364-2204 (Office).

—DOLORES J CONLON, *President-elect*

MEDICAL OFFICE SPACE



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MEDICAL & SURGICAL CLINIC: ree family practitioners located on uth side of Milwaukee, Wisconsin, oking for a full-time internist for busy oup practice, leading to partnership. cellent wages and corporate benefits. r information, please phone, South de Medical Clinic, 414/634-4430 or 4/643-4470. 3tfn/77

NEW PROFESSIONAL OFFICE r lease. Opportunity to plan and de- gn your new office. Up to 2500 sq ft ailable on prestigious East Silver ring Drive, Whitefish Bay area. Air nditioned, carpeted, ample parking. vailable August 1977. For an appoint- ent call Doctor Potter 414/332-3210 414/332-2233. 2tfn/77

OB-GYN, PEDIATRICS SPECIAL- s needed by 16-man multispecialty nic in university community of 50,000 Western Wisconsin; excellent retire- ent and fringe benefits; fine recreation- opportunities; salary negotiable. Send rriculum vitae and references to: John Ujda, MD, LaCrosse Clinic, 212 South th St, LaCrosse, Wis 54601. 9-12/76,1-8/77

WI-FAMILY PRACTICE PHYSI- n wanted, incorporated clinic grp of including family practice and general rgery. Ideal town in Northern Wis, 35 les from Minneapolis. Income guar- teed 1st year. Contact J Craig, New chmond Clinic, SC, New Richmond, is 54017. Tel: 715/246-2231. p11-12/76,1-4/77

FAMILY PRACTITIONER: ONE two to join board surgeon and family actitioner in clinic with attached 82- d JCAH hospital and nursing care it all under one roof. Modern new cilities and equipment 45 miles from inneapolis, rural living with all urban vantages. Financial arrangements open, rvice Corporation. Contact John O nenstad, MD, Osceola, WI 54020. l: 715/294-2116. 4-5/77

FOR SALE: LUCRATIVE, ACTIVE edical practice available in Milwaukee. cellently equipped office. Physician sires to retire. Gross over $100,000 nually—terms. Call 414/462-0100 for ther information. 4/77

DIRECTOR OF MARQUETTE UNI- rsity Health Services. Administer the vices and staff of the Health Center; agnose and treat minor illnesses and uries of students; and supervise educa- n programs in the health service area. D required. Interest in working with dents, and ability to interact with em, a necessity. Previous experience at University Health Service, and pre- ous administrative experience preferred. velve-month position available Sept 1, 77. Salary competitive. Marquette Uni- rsity is an Affirmative Action/Equal portunity Employer. Send application d resumé to James W Sauve, S J, As- tant to the Vice President for Student fairs, Marquette University, Milwau- e, Wis 53233. Deadline Apr 30, 1977. 4/77

INTERNIST AND GENERAL practitioner to join well established medical group. Complete clinic facilities and full hospital privileges. Liberal educational and vacation time. Guaranteed salary and opportunity for early partnership. Rose-Jensen-Manabat, 621 E Walnut St, Green Bay, Wis 54301. Tel: 414/437-4366. 4-6/77

MEDICAL FACILITIES

OFFICE SPACE AVAILABLE: whole floor 3400 sq ft or part of floor for smaller office is desired. Will divide and remodel to your choice. Located in downtown Milwaukee, 174 West Wisconsin Ave. Convenient to all transportation and expressways. Parking garage in rear of building. Suitable for professional offices. Medical or dental laboratory facilities could be developed. Reasonable rent, long term lease if desired. Contact: Jay N Bhore, MD, 414/765-0225 or Patrick Meade, 414/276-1920. 7-12/76, 1-6/77.

FOR LEASE: OFFICE SPACE IN professional buildings adjacent to hospital existing and to be constructed. Specialists and general practitioners. Contact G P Williams, DDS, 1711 Shawano Ave, Green Bay, WI 54303; 1-414/494-9541. 2tfn/77

MEDICAL CLINIC SPACE AVAIL- able, Waukesha area, Wisconsin Avenue Medical Complex with 1,600 sq ft available for rent on both lower and second levels. Owner will decorate. Call 414/257-3500, Settlement Real Estate, Inc. 4/77

FOR SALE: SUITE OF HAMILTON examining room furniture, includes examining table, instrument cabinets, wastebasket, examining stool, diathermy unit and floor model ultra violet light. Contact Frank Kehlnhofer, 4715 N 149th St, Brookfield, WI 53005. Tel: 414/781-7306. 4/77

FOR SALE: WISCONSIN BUSY family practice for sale, well established in the Milwaukee area. May purchase or lease equipment as desired, liberal terms, will introduce, principals only please. Contact Dept 449 in care of the Journal. p4/77

OFFICE SPACE FOR RENT: Courtland Medical Center Building. Excellent location - 68th at West Capitol Drive, Milwaukee, Wis. Full lab and x-ray facilities available. Call 414/463-3704. 3/77*

OFFICE FOR RENT; 5232 W Oklahoma Ave, Milwaukee. Over 600 square feet. Three examination rooms, very large waiting room. Convenient location (bus stop at front door). Attractive low-rise building. Easy on-street and off-street parking. Available now. Tel: 414/476-4666. 12tfn/76

MISCELLANEOUS

ANNALS OF SURGERY, OCTOBER 1976 issue, needed for binding. Willing to pay. John Blackwood MD, 17050 W North Ave, Brookfield, Wis 53005; tel: 414/782-0423. 4/77

WISCONSIN MEDICAL JOURNAL, September 1943 issue, needed for binding, or complete set or volume for year 1943. Willing to pay. *Wisconsin Medical Journal*, Box 1109, Madison, Wis 53701; tel: 608/257-6781, ext 125. 4tfn/77

PROFESSIONAL LEASE SPACE AVAILABLE

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- Occupational Therapy
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- Audiological Evaluations and Screening
- Aural Rehabilitation
- Impedance Testing
- Industrial Hearing Conservation

Contact Administrator
(414) 241-5530
1516 W Mequon Rd
Mequon, Wis 53092

American Association for the History of Medicine

50th Annual Meeting

May 11-14—Madison

Edgewater Hotel

Local arrangements committee: Guenter B Risse, Chairman; Helen Crawford, Judith Walzer Leavitt, Lawrence D Lynch, Ronald L Numbers, John Parascandola, Glenn A Sonnedecker.

Continuing Education Seminars
8:00 am-5:00 pm-May 11
The Wisconsin Center

A. *Traditions of Medical Ethics: Rights and Duties*
Chester R Burns, University of Texas Medical Branch, Galveston

B. *What the History of Professionalization of American Medicine Says to the Profession Today*
Robert P Hudson, University of Kansas Medical Center, Kansas City

Sponsored by the University of Wisconsin Departments of the History of Medicine and Continuing Medical Education in cooperation with the American Association for the History of Medicine (six hours of Category I credit).

Three additional days—May 12, 13, 14—packed full with general sessions, luncheon roundtables, exhibits, boat tours, historical tours, social hours, dinners, business meetings, movies.

Enriching, fulfilling programs that cover the gamut of "Crib Death: Its Medical and Social History," "To Find a Stand: New England Physicians on the Western and Southern Frontier, 1790-1840," "Physician-Chiropractors: Medical Presence in the Evolution of Chiropractic," "Symposium — History, Science, and Politics: Influenza in America, 1918-1976," "Immunization and Public Policy; A Short History of PL 94-380."

Fifty-six guest lecturers from 20 states, Canada, and Paris, France.

Registration fee (per person): $20 for AAHM members; $25, nonmembers, $10 students, $30 member plus accompanying person. Luncheons, tours, dinners, additional.

Further info: **Dr Guenter B Risse,** Department of the History of Medicine, University of Wisconsin, 1305 Linden Drive, Madison, Wis 53706.

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 9, 1976.

THE GREAT LAKES HEMOPHILIA FOUNDATION is sponsoring a one-day symposium on **Hemophilia Care in Wisconsin**

Friday, May 6
The Wisconsin Club
900 West Wisconsin Avenue
Milwaukee, Wisconsin 53233

Program:
- Medical Aspects
- Psycho-Social Problems
- Financial Considerations
- Orthopedic Problems and Management

Registration limited to 150.

Further information contact:

Great Lakes Hemophilia Foundation
1701 West Wisconsin Avenue
Milwaukee, Wisconsin 53233
Tel: 414/344-0772

1977 WISCONSIN

May 5-6: Annual seminar, Wisconsin Society of the American Association fo Respiratory Therapy, The Holiday In —Holidome, Stevens Point, Wis. Info Bill Anderson, Northwest Genera Hospital, 5310 West Capitol Dr, Milwaukee, Wis 53216.

May 6: *Hemophilia Care in Wisconsi* sponsored by The Great Lakes Hemophilia Foundation at The Wisconsi Club, Milwaukee, Wis. See details i box elsewhere in this issue.

May 11: Two short courses in the Histor and Philosophy of Medicine, Wisconsi Center, Madison. See details elsewher in box in this issue.

Fourth Annual Upjohn Lecture Series on DIABETES MELLITUS

Open to public and interested professionals.

Guest lecturer—
Dr Donnell Etzwiler, President American Diabetes Association and Clinical Associate Professor of Pediatrics, University of Minnesota, Minneapolis.

A pediatrician whose primary interest is in education of diabetics about their disease.

Monday, May 2, 4:00 pm
Room 227, SMI Building
UW Center for Health Sciences

Education and Long-term Management of the Diabetic Patient

Monday, May 2, 8:00 pm
Heritage House, 3855 East Washington Ave, Madison

Diabetes—The National Scene

Reservations for dinner can be made through Box 4193, Madison, Wis 53711. $5.00 per person includes meal, beverage, lecture. Social hour: 6:00-7:00 pm.

Credit: *Fully accredited by AMA for Category I.* The afternoon lecture also acceptable for one hour CEH credit.

Sponsored jointly by the Southern Wisconsin Diabetes Association, Dept of Pediatrics, University of Wisconsin-Madison Center for Health Sciences, Dept of Continuing Medical Education-UW Extension.

May 11-14: American Association for the History of Medicine, 50th Annual Meeting, Edgewater Hotel, Madison. See details in box elsewhere in this issue.

May 12: *Staff Burnout Syndrome,* Winnebago Mental Health Institute, Winnebago. See details in box elsewhere in this issue.

May 25: *Child Psychiatry Workshop,* Winnebago Mental Health Institute, Winnebago. See details in box elsewhere in this issue.

May 25: One-day symposium on *Office Dermatology* 1977, at Hoffman House-Midway Lodge, LaCrosse. CME program of Adolf Gundersen Medical Foundation with LaCrosse Lutheran Hospital. Approved for AMA-PRA Category I credit. Info: Clyde C Lawnicki, MD, via Judith Christopherson, Admin Asst, Medical Education (Phone: 608/782-7300, ext 2281).

Jun 3: Annual Scientific Sessions of American Heart Association/Wisconsin Affiliate, at Performing Arts Center, Milwaukee. *Pre and Post Hospital Aspects of Myocardial Infarction.* Info: Ms Pat Erdmann, AHA/Wisconsin Affiliate, 795 North Van Buren, Milwaukee, Wis 53202. Tel: 414/271-9999.

Jun 25: Leukemia Society of America Medical Symposium, sponsored with the Medical College of Wisconsin, Milwaukee. See details in box elsewhere in this issue.

Jul 17-22: Eleventh Annual Summer Institute: *Strengthening Community Programming in the Field of Alcohol Abuse and Alcoholism,* University of Wisconsin Campus, Madison. Info: Richard F Buckley, Associate Professor, Center for Social Service, UW-Extension, 322 Lowell Hall, 610 Langdon St, Madison, Wis 53706.

Sep 10-11: *Academic Anesthesia: Fifty Years After* Conference, University of Wisconsin, Madison. Objectives: The appointment of Ralph M Waters, MD

1977 Annual Symposium on Acute Leukemia

The State of the Art—A Dialogue Between Clinicians and Research Workers

Saturday, June 25—Milwaukee

Sponsored by the Medical College of Wisconsin in association with the Leukemia Society of America

Faculty, thus far, consists of the following distinguished scientists:

Prof Dirk W vanBekkum, Director of Radiobiological Institute, Rijswijk, The Netherlands. He is former president of EROTC—European Research Organization for Treatment of Cancer—and Professor of Medicine at Leiden University and at Rotterdam University.

Dr Leon Shwartzenburg, Associate Director, Institut d Cancerologie et de' Immunogenetique, Villejuif, France. He is an outstanding authority on immunotherapy of acute leukemia.

Frank M Schabel Jr, PhD, Associate Director, Southern Research Institute, Birmingham, Ala.

John Kersey, MD, Associate Professor, Department of Pathology, University of Minnesota School of Medicine.

Robert Truitt, PhD, Special Fellow, Leukemia Society of America, Inc and Research Associate at Winters Research Laboratory, Mt Sinai Medical Center, Milwaukee.

Further details will be announced in May issue. Info: Leukemia Society of America, Inc, Wisconsin Chapter, 411 East Mason St, Milwaukee, Wis 53202.

Eighteenth Meeting

Wisconsin Neurological Society
Friday-Saturday, May 13-14
Olympia Princess, Oconomowoc

Meetings of the WNS are open to all interested physicians and allied health personnel. This meeting is approved for Category I credit. The Wisconsin Neurological Society is accredited for Continuing Medical Education. Following is the program:

Friday, May 13—8:30 to 11:00 PM
Round table discussion of *Unusual Diagnostic and Treatment Problems.* Moderator: Kenneth M Viste Jr, MD, Neenah-Appleton, President, WNS. These discussions are highly informal and serve the purpose of solving or trying to solve the diagnostic and treatment problems faced by members and guests.

Saturday, May 14
9:00 AM: *Atrial Myxoma in Childhood—The Neurological Spectrum.* Michael S Narus, DO, Milwaukee, and Harvey E Cantor, MD, St Louis, Mo.

9:20 AM: *Metrizamide: A New Contrast Medium for Neuroradiology in Children.* Herbert M Swick, MD; Victor M Haughton, MD; and John R Sty, MD, Milwaukee

9:40 AM: *Familial Paroxysmal Movement Disorder.* David Goodenough, MD; Ruggero Fariello, MD; and Raymond W M Chun, MD, Madison

10:20 AM: *Alpha Coma: Report of Eleven Cases.* Paul G Gottschalk, MD; Phiroze Hansotia, MD; and Jerry Berendes, R EEG T, Marshfield

10:40 AM: *Cysticercosis Cerebri Presenting As Focal Motor Epilepsy.* Thomas V Nowak, MD and Jerome V Murphy, MD, Milwaukee.

11:00 AM: *Genetic Study of Focal Seizures.* M Fischer-Williams, MD; David S Dahl, MD; and Meyer S Fox, MD, Milwaukee

11:20 AM: Lunch

AFTERNOON SESSION: *Neuro-ophthalmology*
1:30 PM: **Guest Speaker—Richard E Appen, MD, Madison.** *Optic Neuritis—Genus and Species.*

2:15 PM: *Ocular "Bobbing" in a Child.* Kenneth M Viste Jr, MD, Neenah-Appleton.

2:30 PM: *Oculocranial Somatic Syndrome: Report of Two Cases.* Floyd V Burton, MD; Paul G Gottschalk, MD and Phiroze L Hansotia, MD, Marshfield

2:45 PM: *Congenital Oculomotor Apraxia: Study of Five Cases—A Retrospective.* William W Orrison, MD; William C Robertson Jr, MD, and Richard E Appen, MD, Madison

3:20 PM: *Fibromuscular Dysplasia of the Intracranial Posterior Circulation: A Discussion of Three Cases and Treatment.* Phillip M Green, MD and Marc Letellier, MD, Marshfield

3:45 PM: **Business Meeting.** Kenneth M Viste Jr, MD, Neenah-Appleton, President, Wisconsin Neurological Society. WNS meets semi-annually, in late October and in May. Scientific meetings are open to all interested physicians. Members and guests are required to register so their attendance can be verified for accreditation for CME. Suggestions for improvement of the program are welcomed from members and guests.

Abstracts of the papers presented at this meeting will appear in future issues of the *Wisconsin Medical Journal.*

Officers of the Wisconsin Neurological Society are as follows:
PRESIDENT: Kenneth M Viste Jr, MD, Neenah-Appleton
PRESIDENT-ELECT: Paul G Gottschalk, MD, Marshfield
VICE-PRESIDENT: Clark E Danforth, MD, Milwaukee
SECRETARY: Raymond W M Chun, MD, Madison
SECRETARY FOR CONTINUING MEDICAL EDUCATION: Francis M Forster, MD, Madison

University of Wisconsin-Madison Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

CME Calendar—1977

May 5: *Nurse/Physician Team Program*, St Marys Hospital Medical Center, Madison. Fee: $21 series, $7 individual programs.

May 11: *Short Course in the History of Medicine*, The Wisconsin Center, Madison. Fee: $65.

May 12-13: *An Industrial Injury Clinic*, The Pioneer Inn, Oshkosh. Fee: $100.

May 13: *Society for Neuro-Science*, The Wisconsin Center, Madison.

May 18: *Maternal and Infant Care: Intrapartum Problems I*, Beaver Dam Community Hospitals, Beaver Dam.

June 15: *Maternal and Infant Care: Intrapartum Problems II*, Beaver Dam Community Hospitals, Beaver Dam.

June 22-25: *The Society of Psychotherapy Research*, The Wisconsin Center, Madison.

Aug 10-12: *The Second International Meeting on Tryptophan Metabolism: Biochemistry, Pathology and Regulation*, Dr Ray Brown, Chairman, The Wisconsin Center, Madison. Fee: $70.

Aug 16-19: *Educational Resources*, The University Bay Center, Madison.

Aug 29-Sep 2: *Emergency Care Conference*, The Wisconsin Center, Madison.

Sep 10-11: *50th Anniversary Anesthesiology Program*, The Wisconsin Center, Madison. Fee: Members $27; Nonmembers $62.

Sep 15-18: *Family Practice Review Boards*, The Edgewater Hotel, Madison.

Sep 16-17: *Plastic Surgery for the Primary Care Physician*, The University Bay Center, Madison.

Sep 21: *Maternal and Infant Care: Infant Assessment and Early Management*, Beaver Dam Community Hospitals, Beaver Dam.

Sep 30-Oct 1: *Hospital Administration*, The University Bay Center, Madison.

Sep 30-Oct 1: *A Conference on Dermatology*, The Wisconsin Center, Madison.

Sep 30-Oct 1: *Trauma Symposium*, St Marys Hospital Medical Center, Madison.

Info: Coordinator, Dept of CME, 601 Walnut Street, Madison, Wis 53706; phone: 608/263-2850.

to the faculty of the University of Wisconsin in 1927 marked the beginning of a new era in anesthesiology. All sessions at Wisconsin Center. Conference fee: $27 for members of Wisconsin Society of Anesthesiology, $62 nonmembers. Info: CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

1977 NEIGHBORING

May 6-7: *Clinical Genetics*. CME program of University of Minnesota, Minneapolis. Acceptable for credit toward AMA-PRA. Info: Office of Continuing Medical Education, UM Medical School, Box 293 Mayo Memorial Bldg, Minneapolis, Minn 55455; tel 612/373-8012. g5/77

May 12-14: *Practical Dermatology in Primary Care*. CME program of University of Minnesota, Minneapolis. Acceptable for credit toward AMA-PRA. Info: Office of CME, UM Medical School, Box 293 Mayo Memorial Bldg, Minneapolis, Minn 55455; tel 612/373-8012. g5/77

Jun 15-17: Three-day international symposium on *Fermented Food Beverages in Nutrition*, cosponsored by Mayo Clinic-Mayo Foundation and The Nutrition Foundation, at Rochester, Minn. Will explore the dietary role of fermented food beverages, such as beer

Administrative Medicine Summer Studies (Inter-Session)

University of Wisconsin-Madison Medical School
May 31—June 17

Health Care Planning, Evaluation, Management Graduate Credit Courses for Health Professionals

Three short graduate courses and a seminar have been specifically designed for practicing physicians and other clinicians in leadership positions in their communities, their health care organizations, or their medical education institutions.

PM 701 Clinical Administration in Health Care Systems
(3 credits) Analysis of health care systems in light of organizational and small group constructs applied to problems encountered by clinicians in leadership positions. Includes provisions for simulation and other experimental learning opportunities. Delbecq and Calkin, instructors.

PM 702 Health Care Planning
(2 credits) A course addressing concepts, definitions, processes, and tools useful to health planning. This course will focus on health planning data and models used in evaluation and the appropriateness of existing services. The need for proposed health services and recommended allocation of resources for developing facilities will also be addressed. Gustafson and Sanders, instructors.

PM 703 Health Care Evaluation
(2 credits) Components of evaluation processes for health services are studied, including theoretical development design, measurement, analysis, and implementation of results. Evaluation of systems, organizations, programs and professionals are considered. Emphasis is placed on quality of care assessment. Rose and Noren, instructors.

PM 704 Seminar: Management in Health Care
(1 credit) This seminar will integrate the course work covered in the previously listed courses by using the case and critical incident methods. Management problems, resource allocation problems and the effect of predominant values upon decision making will be emphasized. Detmer, instructor.

Administrative Medicine courses offered in the Inter-Session have been accredited for continuing medical education by the University of Wisconsin Department of Continuing Medical Education as meeting the criteria for Category I of the Physician's Recognition Award of the AMA for the following number of credit hours: PM 701—58 hours; PM 702—32; PM 703—40; and PM 704—18.

Time demands of these courses are such that students should free themselves of clinical responsibilities during the three-week Inter-Session.

Faculty: **Don E Detmer, MD,** Director of Administrative Medicine Program and Assistant Professor of Preventive Medicine and Surgery. **Jay Noren, MD, MPH,** Administrative Medicine Associate Director and Assistant Professor of Preventive Medicine. **Joy D Calkin, MScN,** lecturer of Pediatric Nursing and Health Services Administration. **Andre Delbecq, DBA,** Professor in the Department of Management, Graduate School of Business. **David Gustafson, PhD,** Professor in the Department of Industrial Engineering and Preventive Medicine. **Jerry Rose, MBA,** shares responsibility for quantitative courses in the Health Services Administration Program with David Gustafson. **Jerry Sanders, PhD,** Professor and Chairman of Industrial Engineering and Professor of Preventive Medicine.

Applications to: Administrative Medicine Offices, UW-Madison, Center for Health Sciences, 1225 Observatory Drive, Madison, Wis 53706. Additional info: Don Detmer, MD (phone: 608/263-4886) or Jay Noren, MD (phone: 608/263-6294).

and wine. More than 50 scientists from the United States and other countries will present papers. Info: Dr Clifford Gastineau, Dept of Endocrinology, Nutrition and Internal Medicine, Mayo Clinic, Rochester, Minn 55901. g4-5/77

1977 AMA

Mar 30-Apr 1: 30th National Conference on Rural Health, Seattle, Wash, Washington Plaza.

Jun 18-22: AMA Annual Meeting, San Francisco, Calif, Fairmont Hotel and Tower; San Francisco Convention Center—Brooks Hall.

Aug 8-13: "Medinfo '77"—2nd International Conference on Medical Computing, cosponsored by the Canadian Medical Association, International Federation for Information Processing; and World Health Association.

Nov 10-11: AMA 16th National Conference on Physicians and Schools, Regency Chicago, Chicago.

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Workshops for Health Professionals

A series of Continuing Medical Education conferences, offering 15 credit hours in Category II. Emphasizing how to use Biofeedback and transcutaneous electrical nerve stimulation in your practice. Write for brochure:
The Pain and Health Rehabilitation Center
Route 2—Welsh Coulee
LaCrosse, Wis 54601
Tel: 608/786-0611

CONFERENCES FOR MEDICAL PROFESSIONALS.

Over 500 listings of national/international meetings, conferences and seminars in the medical sciences for 1977. Send a $10.00 check or money order payable to Professional Calendars, PO Box 40083, Washington, DC 20016. p1-6/77

Regional Conference on Aging
Monday-Tuesday, May 16-17
Sheraton-Chicago Hotel, Chicago

A comprehensive conference for professionals and others serving the aging from a multi-state area, to explore a multi-disciplinary approach to aging concerns and interests, to provide a more comprehensive background of information, and to create an educational arena for establishing contact with those from other states, exchanging practical experience, knowledge, and program approaches.

Those particularly interested would include social agency staff, nurses, clergymen, dietitians, social workers, administrators, trainees, students, planners, volunteers, and others.

Registration fee: $60. Illinois Dept of Public Health has approved this program for CME credit.

Info: IAHA—Illinois Association of Homes for the Aging, 3300 West Peterson Ave, Chicago, Ill 60659; phone: 312/583-9850.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

April 18 through May 1

The Cyanotic Infant: Finding the Cause and *Cyanotic Heart Disease in Infants,* with Richard J Golinko, MD, Director of Pediatrics and Pediatric Cardiology, The Brookdale Hospital Medical Center in Brooklyn, NY.

Corticosteroid Therapy and Inflammatory Bowel, with John V Carbone, MD, Professor of Medicine, and Director of Student Teaching, Department of Medicine, University of California, San Francisco.

May 2 through May 15

Systemic Mycoses: How to Select and Interpret the Tests, with John E Bennett, MD, Head of the Clinical Mycology Section, Laboratory of Clinical Investigation, National Institute of Allergy and Infectious Disease, Bethesda, Maryland.

Hypertensive Emergency Workshop, with Harriet P Dustan, MD, President, American Heart Association, and Vice-Chairman of the Research Division, the Cleveland Clinic Foundation; Edward D Frohlich, MD, Head of the Section on Hypertensive Diseases, Ochsner Clinic, and Vice-President for Education and Research, Alton Ochsner Medical Foundation, New Orleans; and Gerald E Thomson, MD, Director of Medicine at Harlem Hospital Center and Professor of Medicine, Columbia University College of Physicians and Surgeons, New York City.

May 16 through May 29

Ovarian Cancer Management: The Planned Attack, with Hugh R K Barber, MD, Clinical Professor and Director of Obstetrics and Gynecology at Lenox Hill Hospital, attending surgeon of the Division of Gynecology of Memorial Hospital, New York City, and President of the New York City Division of the American Cancer Society. Gait: Normal and Abnormal, with Robert S Siffert, MD, Professor and Chairman, Department of Orthopedics, Mt Sinai Hospital, New York City.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in most videotape and videocassette formats.

CONTRIBUTIONS—CES FOUNDATION
February 1977

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for February 1977.

Unrestricted

Richard Biek, MD; Polk County Medical Auxiliary; Barron-Washburn-Sawyer-Burnett County Medical Auxiliary; Anonymous—*Voluntary contributions*

Restricted

Merck and Company, Inc—*Speakers' Service*
Wyeth Laboratories—*Medical Student Summer Externship Program*
Brown County Medical Auxiliary—*Brown County Loan Fund*
Membership Dues—*Aesculapian Society*

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Brown County Medical Auxiliary—*Mrs Gloria Levitas (Brown County Loan Fund)*
Dr-Mrs. Robert Schmidt—*Cecil Birder; Robert DeCock, MD (Brown County Loan Fund)*
Dane County Medical Society—*J A Grab, MD*
Mr-Mrs LaVerne Johnson—*Arnold Larson*
Langlade County Medical Auxiliary—*Mrs Joseph Lambert*
State Medical Society—*Raymond Powers; Roland H Frederick, MD; AJ Hebenstreit, MD; Arnold Barr, MD; Gerald E Bourget, MD*
Jere and Carol Sabota; Ralph and Jean Anderson; Earl and Alice Thayer; EJ Nordby, MD —*Donald E Gill* ■

NEWS YOU CAN USE

HEARING AID APPROVAL

The Food and Drug Administration has adopted new rules designed to protect people who buy hearing aids. Anyone purchasing a hearing aid must have a medical examination by a physician within the previous six months or sign a statement saying he doesn't want one. People and companies who sell hearing aids must not encourage customers to sign the forms waiving a physician examination.

CME EXEMPTIONS

Several SMS members have inquired about a possible exemption from the new Continuing Medical Education (CME) requirements. Here are the facts: the CME requirement is now part of the Wisconsin professional liability laws. The law says that anyone practicing more than 240 hours per year must meet both the CME requirements and the professional liability requirements. Anyone practicing under 240 hours per year may apply to the State Medical Examining Board for an exemption. The Board's address is: 1400 East Washington Ave, Madison, Wis 53703; tel 608/266-2811.

EMERGENCY RULE FOR PSYCHOTHERAPY SERVICES

The Joint Committee for the Review of Administrative Rules has directed the State Department of Health and Social Services (DHSS) to adopt an emergency rule which permits a person with a master's degree in psychology or social work to receive reimbursement under Title 19 (Medicaid) for assisting a physician. The Committee was considering the DHSS policy regarding reimbursement eligibility of those who assist physicians in providing psychotherapy services under Medicaid. The Committee told the Department the intent of the emergency rule "should be to treat individuals who hold a master's degree in psychology the same as individuals with a master's degree in social work have been treated."

EXPERIMENTAL REIMBURSEMENT FOR PHYSICIAN EXTENDERS

Under present law, the services of physician extenders (PEs) are not reimbursable under the medical insurance part of Medicare (Part B), unless they are rendered under the direct personal supervision of a physician. The Social Security Administration has announced a two-year experimental program which, under certain conditions, will permit payment during this period to physician practices for the *independent* services of physicians' assistants, nurse practitioners, Medex, and similar nonphysician health-care providers. During this two-year period, eligible primary care practices employing PEs will be reimbursed for the PE's services to Medicare beneficiaries where there is no direct physician involvement . . . that is, where the physician does not provide a service directly to the patient during the visit. In order to be eligible to participate in the experiment, a physician must accept full and legal and ethical responsibility for the services delivered by the PE, and the PE's services must be legally authorized by the state in which the services are delivered. Experimental reimbursement for PE services will be made only to a PE employer; there will be no direct payments to PEs. For more information about enrollment in this two-year program, physicians should call collect to the University of Southern California, Division of Research in Medical Education, (Social Security contractor) at 213/221-2147 from 9:00 am to 4:00 pm California time. All such queries must be made by May 1, 1977, since no new eligibility determination will be made after that date.

USE THE CORRECT ADDRESS!

Wisconsin Physicians Service (WPS) reports an increasing number of errors in its correspondence, due to the incorrect addresses of providers still in the files. WPS urges all physicians to keep WPS posted of any address change. Send address changes to Central Provider Code Unit, Box 1787, Madison, Wis 53701. ■

15% REDUCTION IN PROFESSIONAL LIABILITY PREMIUMS, PLUS MORE!

The Board of Governors of the Wisconsin Health Care Liability Insurance Plan has voted a 15% reduction in premiums for the next rate period. In addition, the Board voted a 50% reduction in the assessments for the Patients Compensation Fund (umbrella coverage). The complete story appears elsewhere in this issue of WMJ.

NEW PHYSICIANS ALLIANCE COMMISSION OFFICERS

Kenneth Viste Jr, MD of Neenah was elected chairman of the SMS Physicians Alliance Commission at its April 22 meeting in Madison, succeeding Raymond Watson, MD, Milwaukee. Selected as vice-chairman was Jordon Frank, MD of Beloit, succeeding Frederick Kriss, MD of Madison.

THAYER FILES FORMAL COMPLAINT AGAINST THE MILWAUKEE JOURNAL

SMS Secretary Earl Thayer has filed a formal "charge of unethical conduct" against *The Milwaukee Journal* editor Richard Leonard, managing editor Joseph W Shoquist, and the reporting staff involved in a recent series on Medicaid providers. The complaint was filed with Sigma Delta Chi, the professional journalism fraternity. In the series, a reporter, apparently using a false Medicaid identification card, went to five Milwaukee area physicians, and lied, claiming he had a sore throat. The physicians, believing the patient, prescribed various medications and courses of action. The articles in the series then alleged the physicians had given care which was perhaps excessive, imprudent, or questionable. In his letter to Sigma Delta Chi, Thayer noted that the articles appeared to challenge the medical profession and the State Medical Society to investigate the care provided, and to determine its quality. However, *The Journal* refused on at least two occasions to provide the Society with the names of the physicians so that an investigation could be initiated.

Thayer wrote, "*The Journal* articles seriously impugn the reputation and moral character of some physicians, the medical profession in general, and very specifically the State Medical Society. By refusing to divulge the names and other facts, *The Journal* denies individual physicians the right of response and denies the medical society its right to effectively review conduct, and if necessary, to discipline its members and thus obstructs any effective reply by the Society. This seems a clear case of unethical conduct by *The Journal* staff." The Secretary continued, "The use of apparently fraudulent Medicaid cards by *The Journal* reporters and their deliberate lies to the physicians about symptoms is a case of base conduct while professing high moral purpose. Such conduct is inherently unethical, especially since the reporters knew, or should have known, that 'sore throat' is a condition of which the patient is often the only true judge."

Sigma Delta Chi's executive officer, Russell Hurst, responded to Thayer, saying Sigma Delta Chi has "neither the staff, resources nor mandate to investigate complaints against news organizations." The president of Sigma Delta Chi is Richard Leonard, one of those charged in the complaint. Thayer wrote back to Hurst, and indicated that if a Code of Ethics cannot be enforced, there is little use for its existence. Thayer plans to file the complaint now with the National News Council in New York City. ■

the wisconsin medical journal

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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—*Editorial Associates*

$300,000 Ripoff

ALTHOUGH THE word "ripoff" is not one of the favorites in my vocabulary, it best describes this situation. Approximately 2,500 physicians are insured with the Wisconsin Health Care Liability Insurance Plan. The WHCLIP makes a payment of $125 to any licensed insurance agent in Wisconsin who submits an application for coverage under the plan on behalf of any physician. If the physician renews his policy through that same agent, an equal amount is paid as a renewal commission. However, if the physician submits his application on his own without going through an agent, and this is done by about fifty percent of the physicians who are covered by the plan, no original renewal commission is paid to anyone—nor is any reduction made in the premium.

First of all, there is not an insurance agent in the state of Wisconsin who could conceivably fill out this form without getting almost all the information from the physician himself. Conversely, since half of the physicians are already submitting their forms without the help of insurance agents, it is obvious that the rest of them should be able to do the same. The amount involved totals well over $300,000. The commission mechanism would best be totally eliminated. If that can not be accomplished, the amount should be refunded to any physician capable of filling his own application blank.

Although there may be more genteel terms, it still looks like a ripoff of almost a third of a million dollars.—VSF

Some Straight Talk

FOR AS LONG as I have practiced medicine there have been rumblings about physicians whose professional activities were at least on the questionable side. Now and then a flagrant violation brought censure, or even loss of license. Just these past two years, however, pressures from outside are increasing.

First, the newspapers have been active in suggesting careless medical practice or sometimes fraud. Several medical committees were formed but very little happens because (a) such committees of physicians are physicians, not detectives, and (b) even if they find obvious flaws in someone's practice, referral to the State Medical Examining Board has produced limited results more a result of timidity than lack of authority.

State Representative Joseph Czerwinski, chairman of the Assembly Committee on Health and Social Services, has asked in a manner we as physicians cannot ask, for a "review of current administrative rules, since present rules do not contain any specific provision listing the . . . (practices described in *Milwaukee Journal* series) . . . as unprofessional conduct." Representative Czerwinski wrote, "I strongly encourage the Medical Examining Board to take whatever steps are necessary to amend the rules to indicate that quality of care and manner in which patients are treated is a responsibility of the Medical Examining Board."

Most responsible physicians can only agree that some sort of standards do indeed exist, and might, with concerted effort, be spelled out and even useful to those who are trying to hold the medical profession in its current good position in the public eye. Even though polls show a slip in our position of esteem, we still rank high; not all pressures against us are because they hate us. Some pressures against our relatively lax systems might, in the long run, be even to the advantage of the overwhelming bulk of physicians; zeal to protect a few can backfire.—RH

Shades of Things to Come

THE ISSUE OF advertising, within the practice of medicine, is an old one. Various methods are used, the best being good service with gradual building of referrals from satisfied patients. Those who do not choose this method have other options: join with an established practitioner, or group; become active in community affairs; and more subtle systems have now and then been devised, sometimes successfully. Direct advertising is something so new that few of us have given it much thought. But there continues pressure from various well meaning (perhaps) consumer groups who feel the individual patient would benefit if he could "shop" for his physician, compare prices for any particular service. Some of this same thinking may be involved in the pressure to allow free choice of "means" of therapy; divergent groups, as chiropractors, as well as all the new burgeoning ancillary "sciences" of medicine also contribute.

Recently on vacation I clipped an ad from the *Atlanta Constitution* (page 7a, Apr 5, 1977) which starts with a caduceus then these words: Protect your

most valuable asset (then in letters three times as large: YOUR HEALTH). This was followed by a phone number, the type-of-service "center" and this caption over a list of problems: "Your health can be screened for many health problems;" followed by ten "problems," as heart disease, liver disease, and the like. Then in a box you see a large print "Only $40 complete" for "modern lab and testing procedures performed in just a few minutes." Then a list: EKG, Chest X-Ray, Urinalysis, 24 Blood Tests, Blood Pressure, Blood Count. Then in much smaller print, "after the tests are completed they will be analyzed by a licensed physician and you will receive a complete written report of the results."

Now how does that compare with your practice? Can you do all this in a few minutes, furnish a "licensed physician" to analyze results, and print out results? What happens next, assuming anyone of the tests should deviate from some presumed norm? The ad doesn't say, but anyone can guess. For a number of years it was only psychiatry that was being eroded by outside but separately "certified" specialists; now comes the inroad upon the rest of medicine, prescription power for optometrists, autonomy of various sorts for the nursing profession, and with the least imagination similar assumption of increasing bits of medicine.

This ad, not from Wisconsin, tells one more bit of the story we need to hear; perhaps we cannot stop the social pressures but if aware of each one, we can at least help limit and direct the action. It's a cruel

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paradox that the doctrine of *laissez-faire* in medical care is so strongly supported by the very persons who otherwise appear most "liberal," in whatever wide variety of social meanings that term has.—RH

The Nursing Home Pressures

UNDER THE admirable pressures from Lt Governor Martin Schreiber, we are all more aware of the difficult problems that exist in the care and management of our elderly population. In fact our SMS has recently proposed the creation of a better (centralized) mechanism to investigate either inadequate or improper treatment of nursing home patients. Now until such time as we can conceptualize, and afford, some other system of caring for the elderly, our present system must remain.

As both Lt Governor Schreiber and the SMS know the existing set up is complex, involving many individual patients, administrative staff persons, medical and nursing personnel, multiple therapists, and both public and private agencies. All these named groups contribute to the welfare and can be part of the monitoring system, since it seems to be needed. But please note that the variegated tasks required to coordinate all these persons, including the patient's own initiative in health matters, require complex administrative skills and not just the medical skills we learned in medical schools.

While the physician must be a part of the search for better methods of care, for better methods to get adequate care to each person, and for better methods of detecting flaws in the entire delivery system, he would do well to seek the skills of those who have successfully managed divergent groups, and divergences within any given group. This means primarily the permanent staff of your own SMS, who have functioned well, or so the majority believe, in other sorts of group processes. To fail to do so would be to invest medical education with qualities it may not have; individual physicians function as administrators in spite of their medical education, not because of it.—RH ■

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LETTERS

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin.

Usual and Customary Fee

To Fellow Providers of Health Care: In a Surgical Care-Blue Shield Monthly Bulletin dated Volume IV, Number 3, for March and April, it is stated that the fee level considered to be customary as of March 31, 1976 will be maintained for services throughout the remainder of 1976 and 1977. Following this statement is a unit value reduction and a statement of the procedure number preceded by a square and followed by a circle. The square denotes a team fee, and the circle denotes a decrease in value. I bring this to your attention because the usual and customary fee in your community is obviously no longer the usual and customary fee—it is what the Surgical Care-Blue Shield Board of Directors says it is.

Also, in the case of individual practitioners, the team fee concept is simply a euphemism for fee splitting and is directly contrary to medical ethics and to the expressed rules and regulations of the hospital staffs and the Wisconsin Surgical Society.

To those of you who think that heart surgeons' fees are no concern of yours because you do not do heart surgery, I can assure you that if the fees for heart surgery can be changed and the assistant's fee eliminated simply by an order of the Surgical Care-Blue Shield Board of Directors, next month gallbladder or stomach surgery or anything you care to name can be changed in the same manner.

Surgical Care should be required to either sell a policy that provides a dollar indemnity or it should pay the usual and customary fee in the community as it says it does. To do otherwise is simply dishonest. To take the usual and customary fees and supplant them with an arbitrary rule of the Board of Directors is changing the terms to suit the convenience of the insurance company. George Orwell would be proud!

JACK A KILLINS, MD
Green Bay, Wisconsin

April 26, 1977

Bleeding Meckel's Diverticulum

To the Editor: After reading the article in the April 1977 issue of the *Wisconsin Medical Journal* by Doctors Rowan and Hansen concerning the diagnosis of bleeding Meckel's diverticulum, I feel a few comments are in order. This classical, textbook description of a bleeding Meckel's should have been diagnosed and treated without the need of a technetium scan. The fact that this is a "non-invasive, relatively easy to perform" study, in my mind does not justify the test. In this day of ready availability of scans of all types including total body scan, I feel we are not looking at this from a cost-benefit approach.

No wonder the public and governmental outcry about the skyrocketing medical costs. We as physicians are not doing our part in cost control.

JAMES T MURPHY, MD
LaCrosse, Wisconsin

April 29, 1977

"Nursing Home Consumers Who Care"

To SMS Members: "Nursing Home Consumers Who Care" is being organized to serve within the Dane County area. It is the organization's hope to promote community interaction with the residents in a nursing home who are still citizens in our community. The community involvement will insure and continue to insure quality of care and quality of life to those persons who need the services of a nursing home.

There are three main goals: (1) To provide for consumers a comprehensive directory of Dane County Nursing Homes and Alternative Care Facilities within the area. This directory will give communities a better idea of what nursing homes can and do offer. (2) Recruiting and training volunteers to meet individually with each administrator of the nursing home to solicit his or her aid in the data collection, with trained volunteers to provide a one-to-one companionship within each center for a period of six months. (3) If problems or concerns arise, the coordinators of the organization will channel them to appropriate areas be they administrators and staff, the ombudsman program, State Health and Social Services Department's Bureau of Health Facilities and Services (Long Term Care), Legal Services Center of Dane County, and/or other services available.

Follow-up will be an important part of the program. Volunteers will be asked to take part in an inservice on June 7, 1977 from 9 am to 3 pm at the Madison Library (Main). The inservice will include the following topics: (a) Theory on the Aging Process and Nursing Care. (b) Volunteers Responsibilities. (c) Patients Bill of Rights. (d) Administrator's View. (e) Developmental Disability and Mental Health.

Continuing education and update will be provided in areas of need expressed by participants.

Physicians wishing more information on this pilot program may call either of the persons listed below.

BECKY GRASSY: 608/251-0616
CAROL MCKY: 608/233-0844
Co-directors
Nursing Home Consumers Who Care

April 27, 1977

Doctor Thanks SMS for Plaque

To SMS Secretary Earl Thayer: This letter is to sincerely thank the State Medical Society of Wisconsin for the beautiful plaque sent to me, which arrived in perfect condition, also for the help given me during the past many years.

I am only sorry I was not more helpful to the Society.

I hope you will be able to carry on without too much political interference, the good work you have accomplished in the past, for the physicians and general public of the State of Wisconsin.

GEORGE J PUGH, MD
110 Gulf View Road
Punta Gorda, Florida 33950 ■

WISCONSIN HEALTH CARE LIABILITY INSURANCE PLAN

15% Reduction in professional liability premiums! 50% Reduction in umbrella coverage assessments!

Wisconsin physicians participating in the Wisconsin Health Care Liability Insurance Plan will soon see a 15% reduction in their premiums for the next rate period. That decision was made last week by the Board of Governors for the Plan. It will become effective July 1977 on new and renewal policies for physicians who get their basic $200/600 protection from the state plan.

That reduction is partially the result of intense lobbying and staff work by the Physicians Alliance Division of the State Medical Society, in particular Fred Kriss, MD, Madison, chairman of the SMS Ad Hoc Committee on Professional Liability, and the Physicians Alliance staff.

The Board arrived at the reduction by slashing 5% for expenses saved in administration of the Plan, 5% for frequency of claims, and 5% for a one-year credit due to the surplus shown on the Plan's 1976 statement.

A *further savings to all physicians* will be realized in a 50% reduction in the assessments for the Patients Compensation Fund (umbrella coverage). The assessment is now 10% of the base premium. The assessment for the new rate period will be 5% of the reduced rate a physician would pay for the Wisconsin Health Care Liability Plan.

Additionally, the Board of Governors eliminated the Plan's system for surcharging for malpractice suits filed against physicians. What does this mean in dollars and cents to physicians in Wisconsin?

Yearly reduction for physician's premiums in the Plan	$1,200,000
Yearly savings due to dropped surcharge	$ 50,000
Yearly savings for Fund assessments	$1,000,000
TOTAL SAVINGS	$2,250,000

The 1976 Annual Statement for the Plan showed a surplus of about $1,400,000. According to state statutes, the Plan cannot show a profit or retain surplus monies. A portion of the reduction, about $700,000, is shown in the state Plan premium reduction. Since the tax-exempt status of the Plan is not clear at this point, the Board withheld enough money from the surplus to cover state and federal taxes in the event the tax-exempt status is not approved.

Board members indicated that the Board is anxious to return the additional monies to the policy holders as well if the tax-exempt status is obtained. If necessary, the Board is prepared to act on this matter between rating periods. In other action, the Board included:

- Consideration of hiring an outside actuarial service.
- No change in the partnership liability charge of 10%. But the Plan manager was instructed to gather data in this area of liability before the end of the year.
- No change in the 50% extra charge for department heads (pathologists and radiologists), although the Board is willing to consider data on whether 50% is a reasonable assessment of extra liability.
- Approved seeking special counsel to prepare a Friend of the Court brief in support of the panel system, recently challenged in a Supreme Court case on the constitutionality of the panels. (SMS also is preparing a Friend of the Court brief in this case.).
- Approved a special Claims Subcommittee to deal with claims against the Fund, and set up procedures for that subcommittee. ■

A Legislative Guide published by the SMS Physicians Alliance Division has been distributed to those receiving the *Capitol Week* newsletter. The Guide includes important information on legislators, their districts, committee assignments, office addresses, and phone numbers, as well as election results from the past three general elections.

Others wishing a copy may contact the Physicians Alliance at SMS offices in Madison. ■

SMS wins fee-freeze suit!

Dane County Circuit Court Judge P Charles Jones May 2 granted the State Medical Society's request for an injunction to end the freeze on the level of Medicaid charges payable to physicians.

Members will recall that on Dec 23, 1974 the State Department of Health and Social Services, by order of the Governor, froze the level of physicians' compensation under Medicaid on the basis that there were insufficient funds to compensate providers at the level of service and rates then in existence. After negotiations to lift the freeze proved fruitless, the SMS instituted suit against the Department on March 24, 1976.

The Judge's decision enjoins the State from continuing the freeze. The Society's attorneys in the case, Lawton and Cates, indicate that under ordinary circumstances an appeal by the State would be routine if for no other reason than to delay the enforcement of the judgment. The State had 10 days to comment. (This deadline had not been reached at press time.)

The decision is of special significance because it clearly establishes that the Department of H&SS cannot under existing law use a fee freeze as a means to cope with an impending shortage of funds under Title 19 (Medicaid). ■

Wisconsin professional liability laws challenged

Madison attorney Curtis M Kirkhuff, acting on behalf of the plaintiffs in three separate malpractice actions, has petitioned the Supreme Court of Wisconsin to declare unconstitutional portions of the Wisconsin professional liability laws (Section 665, Wisconsin Statutes).

The Supreme Court has agreed to take original jurisdiction in the suit, and the State Medical Society will file a "friend of the court" brief in an effort to gain full clarification of the legal status of the law.

Attorney Kirkhuff challenges the professional liability law as being unconstitutional in the following areas:

- The requirement for two panels unconstitutionally gives away judicial powers reserved for the courts, thus depriving persons of their equal rights under the 14th Amendment.
- The requirement for two types of panels—informal and formal—does not provide equal protection as guaranteed under the constitution. The two panels are appointed and function differently.
- There is a conflict between the professional liability panel and court procedures and the procedures of Section 803.03, which applies to all parties in civil actions. He alleges that all liability actions should be handled the same way.
- Informal panel findings are not admissible in later court actions, formal panel findings are admissable. Kirkhuff contends this is a denial of equal protection. He cites other differences in the operation of the two panels, as well.
- Designers and manufacturers of medical equipment are not permitted as defendants under the definition of "health care provider" in Chapter 37, Laws of 1975. Kirkhuff alleges that this leaves claimants in some instances with no available procedure for prosecution against a manufacturer.
- The Madison attorney alleges a denial of equal protection since management of "future awards" over $25,000 are in the hands of the Commissioner of Insurance. Also, he says the act covers only private practitioners and specifically exempts state, county, and municipal employes.
- Kirkhuff also says the procedure whereby awards for malpractice may have a $500,000 cap if losses in the Plan reach a certain point is a violation of the 14th Amendment. ■

Physicians testify at legislative hearings

- **John K Scott, MD,** Madison, chairman of the SMS Committee on Cancer, testified in opposition to AB 240, which would "legalize" the use of laetrile as an anti-cancer drug. Details of the laetrile controversy appear in the CANCER COLUMN of this issue of WMJ.
- **Elmer E Johnson, MD,** Madison ophthalmologist, testified along with six other ophthalmologists, in opposition to SB 107 which would place responsibility for medical diagnosis of ocular disease in the hands of nonmedical people and would expand the scope of optometric practice far beyond the extent of their education and training.
- **Elmer E Johnson, MD,** testified in support of Senate Bill 191 which places ophthalmic dispensers (opticians) under the regulatory powers of the State Medical Examining Board.
- **Chesley P Erwin, MD,** Department of Pathology, Medical College of Wisconsin, testified against AB 193 which would require an autopsy on victims of sudden infant death syndrome. An amendment to the bill is being considered which would allow parents to object to the mandated autopsy.
- **Carl Eisenberg, MD,** Milwaukee pediatrician and member of the SMS Ad Hoc Committee on Genetic Testing (also a newly elected SMS councilor), testified on AB 299 which relates to testing of infants for metabolic disorders. A number of legislators on the Health and Social Services Committee favor a modification of the bill which would incorporate some, but not all, of the provisions of the SMS draft. ■

SMS introduces legislation on school immunization

At the request of the State Medical Society, Rep Jim Rutkowski and eight other legislators have introduced AB 727, which requires a check on school immunization records of Wisconsin students at the sixth, seventh, eighth, or ninth grade level. This legislation was developed by an Ad Hoc Committee on Rubella last fall. This committee had reviewed legislation from the previous session of the Wisconsin Legislature which would have required a premarital test for rubella. Evidence collected by the committee suggested that such a test would be difficult to complete on short notice and would be relatively expensive.

As an alternative, the committee drafted language which would implement a "pre-puberty" check on the immunization records of students with an eye toward identifying and immunizing those who were missed at their initial entrance into elementary school. ■

"To your good health," popular brochure

Physicians are highly enthusiastic about the new brochure developed by the SMS Communications Department, explaining the rise in health-care costs, especially physician fees.

The brochure, first introduced at the SMS Annual Meeting in April, is titled, "To Your Good Health."

Requests from physicians for copies of the brochure to distribute to patients are coming in by the tens of thousands! Some of the larger orders are being partially filled now due to the tremendous demand, but all orders will be filled as fast as the printing presses, in the SMS offices, can crank out the booklets.

Requests can be directed to the Communications Department, SMS, Box 1109, Madison, Wis 53701; or phone 608/257-6781, ext 117. ■

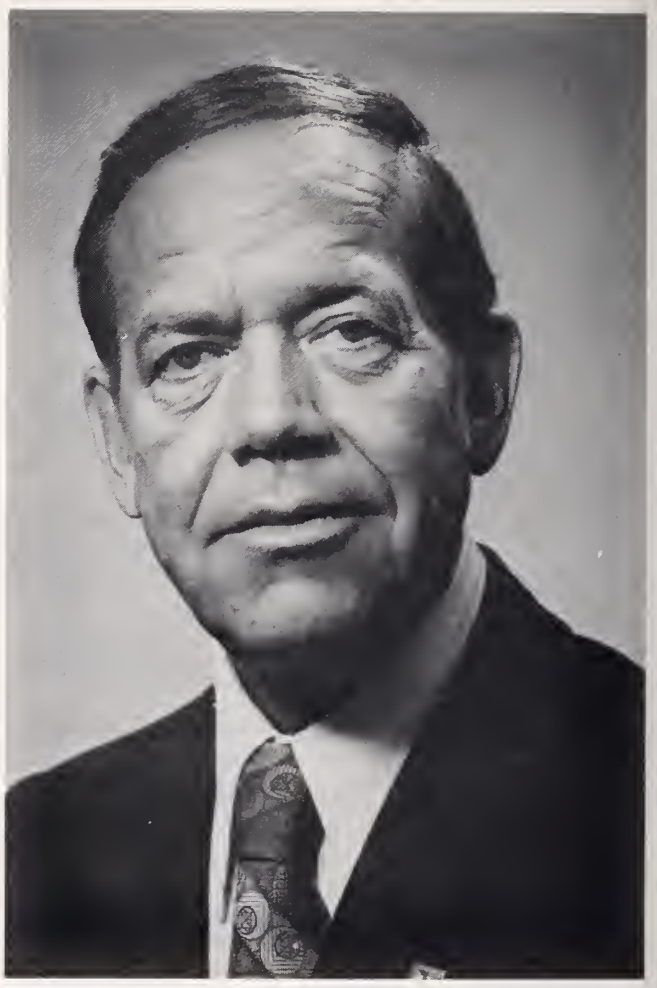
SMS Variable Annuity Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.32 as of March 31, 1977. ■

BEST SCIENTIFIC EXHIBITS
Special Merit Awards

- *Changing Concepts in Management* (Milwaukee Children's Hospital, Milwaukee)
- *Bilateral Osteotomy Cleft Palate Surgery* (Milwaukee Children's Hospital, Milwaukee)
- *Comparative Pathology of the Femoral Head in Hip Joint Disease* (Dept of Orthopaedic Surgery, Medical College of Wisconsin, Milwaukee)

The New President:

Roy B Larsen, MD



Doctor Roy B Larsen, a Wausau surgeon, became the State Medical Society of Wisconsin's 122nd President April 16 during the Society's Annual Meeting in Milwaukee. He was elected to the post at the Society's 1976 Annual Meeting last March.

Doctor Larsen, who practiced surgery for 35 years before becoming vice-president and medical director of Employers Insurance of Wausau in 1974, succeeded Doctor Charles J Picard of Superior.

Born in Denmark, Wisconsin in 1914, Doctor Larsen graduated from the University of Wisconsin-Madison in 1936 as an undergraduate, and earned his medical degree there in 1939. He interned at the University of Oregon Hospitals in Portland, and served his residency at University Hospitals in Madison.

During World War II, he served in the US Army Medical Corps in 1942-1946. He practiced in general surgery in Wausau from 1948 to 1974.

He was a founding member of the Wausau Medical Center in 1962, and has been a delegate from the Center to the American Association of Medical Clinics. He served 10 years on the board of directors, executive committee, and as chief of surgery of Memorial Hospital in Wausau, and was a member of the board of directors and chief of surgery of Wausau Hospitals, Inc.

Long active in organized medicine, Doctor Larsen is a past chairman of the Society's Commission on Scientific Medicine, now the Commission on Continuing Medical Education.

He is a member of the Wisconsin Surgical Society, the UW-Madison Medical School Alumni, and Phi Beta Kappa. He is a fellow in the American College of Surgeons and a diplomate of the American Board of Surgery.

He is a member of the Wisconsin Division of the American Cancer Society and has served as president and chairman of the board.

An active alumnus of his medical school, Doctor Larsen is a past preceptor for the UW-Madison Medical School. He is a member of the board of trustees of the A Ward Ford Memorial Institute, and has served as medical director.

Doctor Larsen, perhaps, is the epitome of a community activist. His service in Wausau area community activities includes Chamber of Commerce, Visiting Nurse Association, YMCA, United Fund, American Red Cross, North Central Area Health Planning Board, Civic Music Association, and the Wausau Police and Fire Commission. He also is active in his church affairs.

Doctor Larsen, a widower, resides in Wausau. He has three sons and one daughter. ■

PRESIDENT LARSEN . . .

Medicine must have one voice

The office of President-elect, which I assumed a year ago, offers a unique opportunity for personal growth. My many years in the House of Delegates and on various committees did not afford an overall perspective of things medical, which this year's service has begun to accomplish.

Most impressive has been my appreciation of the involvement of so many of our fellow physicians in the affairs of the society. A maximum of talent and a multitude of hours are expended yearly for the benefit of all of us. Similarly, the continuous efforts of an excellent and dedicated staff contribute enormously in progress toward our goals.

Each year sees the emergence of new problems confronting the physician in the practice of medicine. The events of the past two or three years contribute to the crises which we must face and hopefully try to resolve.

Briefly, health problems occupy a central portion of the stage at the local, state, and national levels. A three-volume, 600-page study entitled "Health, United States, 1975," was published in 1976 by the US Department of Health, Education, and Welfare. This study indicated that the physical condition of Americans had improved significantly in the past generation, but that excessive use of alcohol and tobacco as well as improper diet and lack of exercise are still major causes of disease. There has been a sharp decrease in infant mortality, and life expectancy has risen in the past decade to 76.7 years for white women and 68.9 years for white men.

The increase in longevity has created new problems in that the United States' elderly population has risen sharply from 1940 to 1970 during which period the number of people over 65 more than doubled to 20.2 million. As a consequence, the incidence of chronic arthritis, diabetes, and other diseases linked with aging also has gone up while heart deaths have decreased in the 55-64 year age bracket. We have seen a rise in cancer deaths, respiratory diseases, kidney and liver ailments, and, particularly among the young, venereal diseases. In 1975 health care cost $119 billion nationally, $45 billion of it for hospitals, a figure that was four times the 1960 cost. In 1976 health care cost $140 billion, a 19 percent increase in a single year. The projected increases for Medicaid and Medicare this year are staggering: Up from $25 billion to $30 billion and from $11 billion to $21 billion, respectively.

Between fiscal years 1950 to 1976, total health-care expenditures rose from 4.5 percent to 8.3 percent of the gross national product. The Medicaid Management Study Team interim report dated November 2, 1976, indicated that for Wisconsin in 1967, the total cost of the health-care and related services provided through the Medicaid program was $81 million. By the end of 1975, the annual cost had grown to $402 million. The report adds that nearly half of this increase could be attributed to the rise in the general price level. The remainder of the increase can be accounted for in large part by the growth and the number of persons served by the program and the additional services the program came to encompass.

President Carter: "In recent years, we've spent 40 cents out of every dollar on hospitalization. In effect, we made the hospital the first line of defense instead of the last."

Specific promises made during the Carter presidential campaign of 1976 ensured that there would be some type of national health insurance in our future. Debate would probably be very active right now were it not that the first priority had been given to balancing the budget. Nevertheless, President Carter repeatedly presented his views and has declared: "Prevention is both cheaper and simpler than

Presented before the House of Delegates of the State Medical Society of Wisconsin at its Annual Meeting, April 14-16, 1977 in Milwaukee.

cure, but we have stressed the latter and we have ignored, to an increasing degree, the former. In recent years, we've spent 40 cents out of every health dollar on hospitalization. In effect, we made the hospital the first line of defense instead of the last. By contrast, we've spent only three cents on disease prevention and control, less than one-half a cent on health education and one-quarter of a cent on environmental health research." He goes on to say that if we were to improve our national eating, drinking and smoking and exercise habits, we could be healthier, be happier, live longer, and save ourselves billions of dollars in the process. These quotations emphasize the obvious, that the medical profession cannot regulate the fact that many people smoke too much, eat too much, exercise too little, drive too fast, don't use seatbelts, work too hard, worry too much, and breathe smog instead of air.

Last month Odin W Anderson, Director of the Center for Health Administration studies of the University of Chicago Graduate School of Business, addressed the annual meeting of the American Association for the Advancement of Science. He predicted that if national health insurance is enacted by Congress that it will be underfinanced and consequently will drain resources needed to resolve other health problems. He further urged that efforts be directed toward catastrophic insurance that protects all segments of the population against high-cost illnesses, comprehensive services for low-income groups, and national efforts to solve problems that have a reasonable chance for improvement. Mr Anderson further adds that the Kennedy-Corman Universal Health Insurance is "utopian on two counts. It is neither politically feasible nor practical to administer." He listed misconceptions as follows:

1. That NHI, of itself, will improve the health of America.
2. That NHI will be a lever for cost control.
3. That NHI will automatically reconstruct the health-care system.
4. That NHI will establish health care as a "right," eliminating the need to spell out acceptable levels of the access and quality of care.

But what then constitutes our specific problem in Wisconsin? We have many, as exemplified by the numerous reports and the resolutions in your Delegates' Handbook, 1977. Nineteen seventy-six marked specific action and progress on many of these fronts, but continuing efforts must be made toward solution of these and newer problems in 1977.

The Physicians Alliance Commission, Report H, enumerates its six established priorities. This committee, through diligent work on the part of members and superb staff performance, has brought the image of the State Medical Society into sharp focus. Because we are a minute percentage of the total population, we must speak with one voice in order to be heard. The best evidence of fragmented medical opinion, and possibly inertia on our part, is reflected in a rather consistently mediocre legislative track record in the past. If we should persevere in an atmosphere of disunity, apathy and indifference, we could well lose the rapport and trust which have been established during this current session of the Legislature.

President Carter: "By contrast, we've spent only three cents on disease prevention and control, less than one-half a cent on health education and one-quarter of a cent on environmental health research."

Now is not the time, with the long shadow of federal intervention hanging over us, to further divide the house of medicine. Specifically, I feel that we need to further strengthen ourselves on the county, state, and national levels. Careful study of resolution number four, to be considered by this House, is recommended.

(Resolution 4 calls upon each Wisconsin physician for "a renewed interest and support of organized medicine as a continuum of county, state, and national effort, rejecting any effort to end the 'Unified Membership' concept and policy in Wisconsin.")

Progressive efforts to resolve the differences between WHCRI and WisPro continue. Both have a significant role to play if we are to have an effective, comprehensive, peer review effort in the state. The private insurance industry is poised and eager to cooperate whenever we have settled our fraternal problems.

Transitional efforts on conversion of WPS to WPSIC have evolved slowly and sometimes painfully. However, within the near future we hope that the conversion will be accomplished

to the satisfaction of this Society as well as to the State Insurance Commission.

During the past year a special committee of the Council began work on the evaluation of the delivery and costs of medical care. This program will be continued, and efforts will be made to cooperate with public health teams who are approaching the same problems.

Certificate of need is mandated under Public Law 93-641 and requires all states to have enabling legislation. The Council of this Society acted unanimously on March 5, 1977, to approve a change in the Society's legislative approach, particularly as it affects physicians' offices. Several certificate-of-need bills have been previously introduced. A complete report was mailed to the membership on March 7, 1977, in which our proposed legislative position was outlined. This step was an extremely necessary one, since we were to be denied participation in the development of a proposal for enactment during this current session unless we offered some constructive alternatives. We will continue to oppose the inclusion of any features which are detrimental to the welfare of the members of this Society.

The problems attendant on the Society's suit against the State Department of Health and Social Services to lift the T-19 fee freeze is adequately dealt with in the Council Report R and will not be repeated here. At this point, I would like to emphasize a portion of the Council report related to planning developments.

President Larsen: The previous quotations "emphasize the obvious, that the medical profession cannot regulate the fact that many people smoke too much, drink to excess, eat too much, exercise too little, drive too fast, don't use seatbelts, work too hard, worry too much, and breathe smog instead of air."

While we seek closer liaison with the State Health Policy Council, it is obvious that the action is in the local Health Systems Agencies. Therefore, we urge active participation by physicians on the Board, in technical committees and in advisory capacities.

Special attention also must be given to the problems of the Wisconsin Medical Assistance Program (Title XIX, Medicaid). Why are we as physicians under attack for all the ills of this program? The Medicaid Management Study Team made an interim report on November 2, 1976, to Mr Carballo, Secretary of the State Department of Health and Social Services. This 50-page report, exclusive of the appendixes, deserves serious study by all who might be involved in seeking solutions to problems which have been raised. Previously in this presentation, I have mentioned that the cost of the total program in 1967 was $81 million and the annual cost had grown to $402 million by the end of 1975. Various excerpts from this report will be given to illustrate reasons for this tremendous increase. I quote, "For example, the unanticipated rise in costs of the Medicaid program does not result predominantly from increases in the prices paid by the Medicaid program for health services, nor from increases in the level of utilization of those services, nor from increases in the level of utilization of those services by program participants. Rather the cost of the Medicaid program grew because the number of people eligible for Medicaid benefits and the number of services covered by the program were increased by state and federal initiatives."

President Larsen: "Now is not the time, with the long shadow of federal intervention hanging over us, to further divide the house of medicine."

While Wisconsin has the distinction of having the lowest cost for administration of Medicaid as a percentage of total program expenditures, it is worth noting that the State Department of Health and Social Services has a staff of 13.5 people which is viewed as entirely inadequate to administer a program of this size. Four factors are listed which have contributed to the rising costs as follows:

1. Increase in the number of persons automatically eligible.
2. Addition of other health-care services to the Medicaid program.
3. Shifts in funding of certain health-care costs to Medicaid from other public sector programs.
4. Extension of available services for the medically needy group.

It was further found that the major portion of the increase in the cost of the Medicaid program in the State of Wisconsin between 1967 and 1976 can, in a statistical sense, be attributed to these four factors and the rise in the general price level. To carry this one step further, I quote, "The increase in costs in a more recent period since 1969 can be completely accounted for by these same four factors and price inflation."

The Interim Report claims that there have been three major tasks which have not been carried out by the fiscal intermediaries in accordance with the contract provisions, namely those of providing statistical reports, calculating units of work to be paid for by DH&SS and auditing of claims. These problems are currently being addressed by the fiscal intermediaries and the Department of Health and Social Services. Since negotiations are now under way, further discussion at this point seems untimely.

Odin Anderson . . . urged that efforts be directed toward catastrophic insurance that protects all segments of the population against high-cost illnesses, comprehensive services for low-income groups, and national efforts to solve problems that have a reasonable chance for improvement.

Doctor Walter McClure of Interstudy will address the socioeconomic luncheon meeting tomorrow. He was an invited speaker to the AMA regional program in January in Florida at which time he said, "In the area of national health insurance, the issue isn't whether there will be change or no change — it's what change will occur and who will lead it."

I would like to close with two quotations, the first of which is by AMA President Richard E Palmer, MD who stresses that "The AMA must have the kind of unity that prevails in foul weather as well as fair. We must listen not for what we want to hear — but what we ought to hear. It is comparatively easy, after all, to secure unity — or the appearance of it — for those policies, programs or proposals on which most of us can agree. It is more difficult to keep larger views and larger obligations in mind, and to be willing to think and act accordingly — even when it hurts."

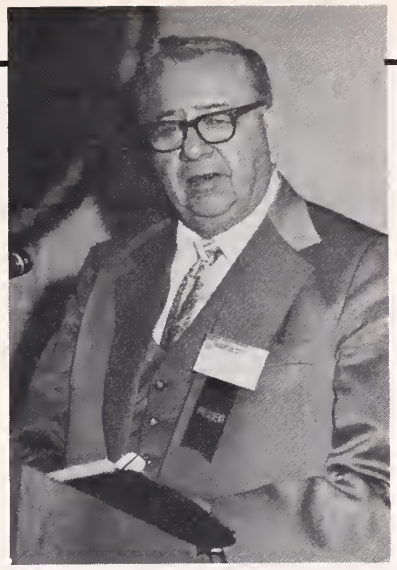
And last, I would like to quote the words of an elder statesman of medicine, one who is widely respected and revered in this state, the late Doctor William S Middleton. In a radio address made on December 5, 1972, he said the following which I will quote verbatim:

"As we come into the medical profession's attitude toward its responsibilities, we realize that in the past medicine has too frequently considered itself the sole protector of the health of the citizenry. Obviously with the social evolution of this and other countries, health is the birthright of every citizen. Accordingly, medicine must fit itself into a new social fabric in which the protection of health, the universal complete medical care during illness and the various measures to rehabilitate must be brought into focus. This means that no longer can medicine stand aside as a final arbiter but must join forces with all of the social agencies, professional and semi-professional, that are interested in the health of the citizenry. Under these terms only by the very cohesive action of groups including producers, dispensers, and consumers of health services can we hope to see a broader and more logical delivery of health care. Under the circumstances of the many agencies so involved without real leadership, medicine has been reluctant to take a subsidiary place. Captain, yes, but team, no. If medicine will bear this particular responsibility in mind, it will realize that while it is not responsible for poverty, pollution, overpopulation or what you will among our social ills, at least as a part of the team responsible for the control of these current social ills, it will then take its part. Under these terms, medicine will be a very much more effective agency of society than at the present time."

Doctor McClure: "In the area of national health insurance, the issue isn't whether there will be change or not change—it's what change will occur and who will lead it."

There is much we must accomplish during the years ahead. If we act in a spirit of unity, marked only by honest divergence of opinion, I believe that we can discharge our duties as citizens for the general good of all. Surely the most sophisticated mechanism for the delivery of health care must fail, if participating physicians are not available to render such care. As providers of care we seek an equal voice in policy and planning necessary to insure the quality of medical service. I would ask all members of this Society to join their energies toward realization of this, our common goal. ■

PAST PRESIDENT PICARD



Together in battle

Twelve short months ago, you honored me by installing me as your President. Since that time, I visited many County Medical Societies. I have done very little talking, but I have done a great deal of listening and learning, with an eye toward seeking answers to medicine's problems. My basic philosophy has always been that we must be part of the solution, and not part of the problem.

It is extremely difficult to completely list and analyze all the problems we face. The major problem, however, is the continuing and growing regulation of the health-care system by the federal and state governments. The bureaucrats are using rising health-care costs as an excuse to further government control of medicine. They also are citing the few examples of questionable medical practice to penalize the vast majority of honest practitioners.

Every phase of American life has its weak spots, more commonly called "bad apples." Almost every phase of society seems to be excused, but not so with medicine. The actions of a few bad apples are flaunted in headlines across the land, and physicians as a group have had to stand accused of fraud and over-utilization. Physician fees only constitute 8 percent of the health-care dollar, and yet physicians must take the brunt of the blame for rising health-care costs.

We have a new administration in Washington. President Carter has made it clear that he will take an activist stance on health issues. That stance by the President is combined with a Congress oriented toward more government regulation, and a Congress without fear of presidential veto.

We can expect a number of heavily federalized national health insurance programs, justified by many of the accusations now being made by various government agencies. I also expect to see the government expand Medicare and Medicaid benefits, without adjusting the provider reimbursement levels. This will be a gift from you and me to the government . . . at our financial loss.

The physician still enjoys the greatest public trust of any profession, and it is my feeling that we must attempt to keep this trust and make others aware of it. The people must know that the programs and plans designed in Washington and Madison are as false as the so-called crisis in health care they were designed to meet. In this state and country, we have the best trained physicians, nurses, and allied health personnel of any nation on earth. We have the best hospitals and health-care facilities in the world. Our citizens are receiving more and better care than anyone else. Our population was never healthier. I say that all the talk about a health-care crisis is completely exaggerated intentionally by the federal and state administrators who want to advance state control.

During the course of the last year, I must admit that perhaps mistakes have been made, and our efforts have not always been unified. But I believe this has been reduced to a minimum. In fact, I think we are more unified than ever before. Unity is absolutely essential. The ever-growing menace of over-regulation by the government will only be fought successfully if we are together in the battle. I can only recall what Ben Franklin told his fellow delegates to the Continental Congress in 1775 — "We must all hang together on this . . . or surely we shall all hang separately!"

Presented before the House of Delegates of the State Medical Society of Wisconsin at its Annual Meeting, April 14-16, 1977 in Milwaukee.

I strongly believe that of all the organizations representing organized medicine, the American Medical Association possesses the expertise and experience to fight best for our mutual interests. AMA has the staff, the research capabilities, the lobbying effort, and the total numbers which impress the politicians in Washington. Politicians are afraid of only one thing . . . numbers. And we have the numbers in the AMA. If they're not afraid of us, at least they respect us.

The AMA has assisted state organizations in continuing medical education. It has led the fight against the new national health planning act in and out of the courts. It is pressing for action against Medicaid fraud, as are we in the State Medical Society. The AMA has also done some excellent research in the areas of professional liability and health-care costs.

In the past year, the physician members and staff of the State Medical Society have prepared and started to put into action a forceful plan of action. Because of our new approach, I am confident that the physicians of Wisconsin will have a significant voice in the key health-care decisions made in the future.

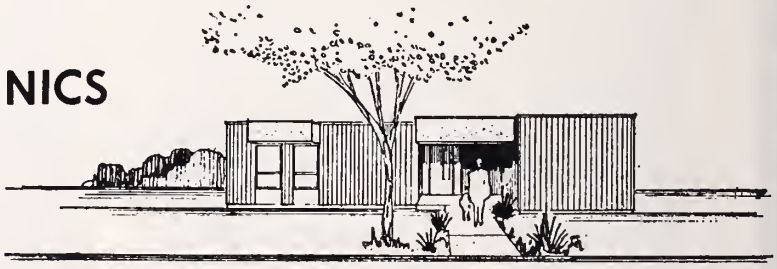
Here are some key goals in the new State Medical Society plan of action:

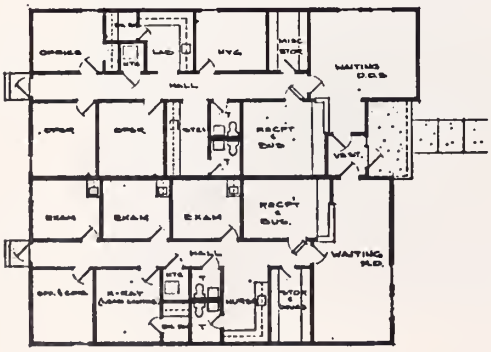
- Active participation in changes in the Wisconsin professional liability laws;
- Increased communication with the membership and the public;
- Development of strong grass-roots relationships between physicians and Wisconsin lawmakers;
- Physician membership and staff monitoring of all important governmental bodies;
- A highly organized lobbying effort at the State Capitol;
- Positive involvement in proposed changes in health-care legislation;
- Continued lawsuit to end the Medicaid fee freeze;
- Emphasis on quality continuing medical education; and
- Assisting physicians in any negotiations with third parties, such as hospitals or insurance companies.

In summary, we have made progress, but there is much more to do. The manner and strength of our effort will depend entirely upon us. And it will depend upon our *unity!*

It is my considered opinion that the State Medical Society, with its commissions, committees, and with the aid of excellent staff, has put together a very strong, vibrant, and growing program. I know this will lead to a stronger, more unified State Medical Society . . . in which the physicians of Wisconsin will have a stronger voice in improving the health care of all Wisconsin citizens. ■

MEDICAL & DENTAL CLINICS





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Summary Report, House of Delegates

State Medical Society of Wisconsin, April 14-16, 1977, Milwaukee

THE FOLLOWING constitutes the summary report of actions taken at the Annual Session of the House of Delegates, April 14-16, 1977, replacing the formal printing of reports and detailed proceedings because of the great expense involved. Resolutions and reports were widely distributed to delegates, alternates, county society officers, and others. Members of the Society may, upon request, study the official transcript of the meeting at the State Medical Society headquarters in Madison, or inquire as to the content of a particular report or resolution.

Earl R Thayer
Secretary

THE HOUSE DELIBERATED 27 resolutions submitted by county medical societies, specialty sections, committees, and members, as well as reports of officers, the Council, commissions and committees of the Society. Refer to the March 1977 *Wisconsin Medical Journal* for a digest of the resolutions. Following is the text of the House of Delegates reference committee reports with indication of action upon their recommendations by the House.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

● REPORT OF THE PRESIDENT: The committee thanks Doctor Picard for his report, recognizes his plea for unity, and wishes to commend his efforts in his tenure of office. We look forward to his continuing contribution as he remains a member of the Council. The committee recommends that his report be adopted. (The full text appears elsewhere in this issue.) ¶Action: ADOPTED

● REPORT OF THE PRESIDENT-ELECT: The committee wishes to commend Doctor Larsen for a very detailed and informative report on economic problems facing medicine. His report is well documented and gives us much to consider. The committee wishes to reinforce his comments concerning the importance of the Society acting in unity but also in the spirit of cooperation with other health planning entities so as to be a major part of a team to provide the best possible quality of medical service. The committee recommends that his report be adopted. (The full text appears elsewhere in this issue.)
¶Action: ADOPTED

● REPORT OF THE SECRETARY: The committee wishes to commend the Secretary for his usual fine report and recommends highly to the membership that it study in detail the comments of the Secretary regarding his views on the British Health Service, and recommends adoption of the report. (NOTE: Copy of the report is available upon request.) ¶Action: ADOPTED

● REPORT R—COUNCIL: The committee wishes to recognize the complex deliberations and actions of the Council and its attention in dealing with the problems presented to the profession; and is glad to see that the Council is continually striving to be of service to both the physicians and the public. The report reviews activities of the Council during the past year as related to the Society's services to the physician, the public, and in strengthening organized medicine at all levels. The committee wishes to support the activities of the Council in continuing its efforts in the suit against the State Department of Health and Social Services to lift its Title XIX fee freeze, and recommends adoption of the report. (NOTE: Copy of report is available upon request.) ¶Action: ADOPTED

● COUNCIL SPECIAL REPORT 2—*SMS Sponsored or Operated Professional Liability Insurance Program*: The committee wishes to commend the Council for thoughtful and detailed consideration in responding to the charge of 1975 Resolution 19 regarding the possibility of a Society-sponsored professional liability insurance company. The committee agrees with its plan of continued observation through the Committee on Economic Medicine and reconsideration of the project at the end of 18 months, and recommends adoption of Council Special Report 2.
¶Action: ADOPTED

● SUPPLEMENTARY REPORT OF COUNCIL—*Item 1 on Thermography*: The committee extends appreciation to the Council for forwarding the definite and direct statement regarding the appropriate use of thermography along with other modalities in the detection of breast cancer as promulgated by the Committee on Cancer. The committee recommends adoption of the revised statement on thermography, as follows:

In the detection of cancer of the breast, the State Medical Society of Wisconsin warns the public against thermography when used as a sole diagnostic or screening tool. It is felt, in light of the current non-discriminate level of positives, as well as the high incidence of false negatives, thermography potentially can give the patient a false sense of security leading to delays in seeking evaluations which could avoid the unfortunate consequences of late diagnosis.

The most effective type of breast cancer detection available at the present time is regular monthly breast self-examination combined with periodic health examination by a physician. Mammography and xerography should be used as indicated in the individual case.

Patients are strongly encouraged to work closely with their personal physicians in all health care problems, including physical examinations, on a regular basis.

¶Action: ADOPTED

● REPORT B—EDITORIAL BOARD: The committee commends the Board for its continuing efforts to maintain the *Wisconsin Medical Journal* as an effective instrument for publishing high quality scientific articles. Your committee further commends the Board for its cost containment efforts and recommends that its report be adopted.
¶Action: ADOPTED

● REPORT D—COMMISSION ON PEER REVIEW: The committee wishes to commend the Commission on Peer Review on its report, and heartily endorses the educational aspects as being among the Commission's principal objec-

tives. The report discusses activities related to referrals from third party payors for review of charges; physician practice patterns under Medicare; relationships with WHCRI and the PSROs. Moreover, your reference committee believes the role of this Commission will become increasingly important and that its efforts will continue to be beneficial to the profession and the public which it serves, and recommends adoption of its report.

¶Action: ADOPTED

●REPORT E—COMMISSION ON PUBLIC AND PROFESSIONAL AFFAIRS: The committee wishes to thank the Commission for its report and wishes also to commend its members for their quiet but effective work in the mediation of differences between physicians and patients or between physicians themselves. During the year the Commission handled 29 complaints from the public and from physicians concerning Society members, and completed with the State Bar of Wisconsin a revision of the Interprofessional Code which will be printed in the June BLUE BOOK issue of the *Wisconsin Medical Journal*. The committee recognizes and concurs with the Commission Chairman's awareness that increased visibility is essential to the carrying out of its charges, and recommends that the Commission on Public and Professional Affairs utilize the facilities of the Commission on Public Information to increase visibility. The committee recommends adoption of Report E.

¶Action: ADOPTED

● REPORT F—COMMISSION ON PUBLIC INFORMATION: Your reference committee wishes to commend the Commission on its efforts. We would recommend that all members read the report carefully and be aware of the advantages of the many valuable services offered. The committee recommends adoption of the report reciting activities on membership recruitment and retention; public service advertising; a communications guide (which will be printed in the June BLUE BOOK issue of the *Wisconsin Medical Journal*); health costs brochure; tape-recorded messages for radio news departments; and a statement of patient rights and responsibilities.

¶Action: ADOPTED

● REPORT J—COMMITTEE ON CANCER: The committee wishes to thank the Committee on Cancer for its efforts and recommends adoption of its report on continuing education in cancer and opposition to proposed legislation to legalize the use of Laetrile in Wisconsin.

¶Action: ADOPTED

● REPORT K—COMMITTEE ON MATERNAL AND CHILD HEALTH: The reference committee was favorably impressed to learn that there is an insufficient number of maternal deaths in Wisconsin to carry out any meaningful statistical analyses. These excellent results are largely attributable to the modern environment of deliveries in the hospital setting. Your committee also is gratified to learn that a cooperative effort has been developed with eight other states in the formation of the Midwest Conference of Maternal Mortality Study Committees. This coalition will provide a broader data base for meaningful evaluation and education. Your reference committee recommends adoption of Report K.

¶Action: ADOPTED

● REPORT L—COMMITTEE ON MEDICINE AND RELIGION: The committee recognizes and commends the continued efforts of the Committee on Medicine and Religion and recommends adoption of its report proposing development of a Speakers Bureau for Medicine and Religion, articles in religious publications, and increased dialogue between physicians and clergy.

¶Action: ADOPTED

● REPORT M—COMMITTEE ON RURAL HEALTH: The committee thanks the Committee on Rural Health for its informative report, and would recommend that it once again become involved in stimulating an annual Wisconsin Rural Health Care Conference. The report covers the several concerns and efforts of the Committee to promote training and location of family practice physicians in rural areas. The reference committee recommends that its report be adopted.

¶Action: ADOPTED

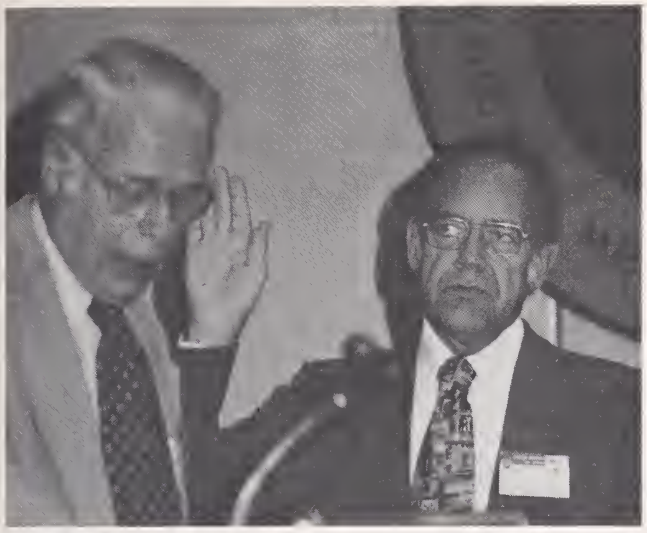
● REPORT O—COMMITTEE ON SCHOOL HEALTH: The committee has reviewed the report of the Committee on School Health and concurs with its findings, which relate to implementation of Chapter 115, Wisconsin Statutes, on services for children with exceptional educational needs, the role of physicians in health education, and committee activities in liaison with the Wisconsin Interscholastic Athletic Association.

No one appeared before the reference committee to explain the rationale for the recommendation that would require first-aid certification of coaches. In the absence of testimony and clarifying information, it is recommended

PRESIDENTIAL CITATION

Robert B L Murphy, Esq

ROBERT B L MURPHY, ESQ (left) received the 14th Presidential Citation award of the State Medical Society at its April Annual Meeting. Presented by outgoing president, Dr Charles J Picard, Superior, the honor recognized Mr Murphy for "his devoted service to medicine as the Society's general counsel for the past thirty-five years, his inspiring love for the professions of medicine and law, and for the privilege of sharing his profound sense of history and humanity." The president of the Society, with the unanimous approval of the Council, has the privilege of presenting the Presidential Citation award to a nonphysician who has made a significant contribution to medicine or public health.



DR ROY B LARSEN (right), new president of the State Medical Society, receives the oath of office from Chairman of the Council, Dr Howard L Correll.

that the statement requesting House of Delegates support of a position requiring first-aid certification for coaches be brought to the House in a more appropriate and definitive manner such as a formal resolution. With this exception, your reference committee recommends adoption of Report O. ¶Action: ADOPTED

● REPORT P—JAIL HEALTH CARE COMMITTEE: The committee wishes to commend the Jail Health Care Committee for its unique action in promoting better health among the inmates of county jails as part of a six-state pilot project to develop standards for ultimate use in a national certification process. Your reference committee recommends adoption of the report. ¶Action: ADOPTED

● RESOLUTION 7—*Reporting by AMA Delegates and Alternates*: Effective communication has been and remains a problem. The committee has confidence that the Council has the capacity to devise a plan which will fulfill the intent of Resolution 7; accordingly, it recommends adoption of this resolution. ¶Action: ADOPTED

● RESOLUTION 25—*Hospital Medical Records Completion*: It is the consensus of the committee that the intent of this resolution can be accomplished within the framework of the hospital medical staff and other nongovernmental agencies. Accordingly, your reference committee recommends that this resolution be not adopted.
¶Action: Resolution REJECTED

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

● REPORT A—COMMISSION ON CONTINUING MEDICAL EDUCATION: This report outlines its activities for the past year and plans for the coming year, including accreditation of continuing medical education programs of hospitals, specialty societies, and county medical societies, and accredited CME programs held and planned by the Society. We commend the Commission for its aggressive efforts and informative report, and recommend its adoption.
¶Action: ADOPTED

● REPORT C—COMMISSION ON HEALTH FACILITIES AND SERVICES: We commend the efforts of this Commission to *effect physician input* into the health planning process and especially the formation of advisory committees in each Health Systems Agency (HSA) area, and recommend the adoption of its report. ¶Action: ADOPTED

● REPORT G—COMMISSION ON GOVERNMENTAL AFFAIRS: With regard to the report of the Commission on Governmental Affairs and its supplemental special edition of *Capitol Week,* we highly commend the work of the physicians of this state in legislative matters and the work of the Commission and its Committee on Federal Legislation. With the introduction of legislation dealing with certificate of need, chiropractic insurance coverage and occupational licensing, active physician involvement is essential. We strongly urge continued emphasis on legislative matters and physician input into these discussions. The reference committee wishes to commend the Commission for the many hours of hard work which will benefit all physicians and the public we serve, and recommends adoption of Report G and the supplementary *Capitol Week.* ¶Action: ADOPTED

● REPORT H—PHYSICIANS ALLIANCE COMMISSION: The reference committee endorses in total the activities of the Commission and appropriate State Medical Society staff in the crucial areas of professional liability, medical defense, and political organization at the local level. The committee specifically encourages the Commission to pursue the suit challenging the Title XIX fee freeze and the five legislative drafts to amend the professional liability law. Also, the committee commends the political organization efforts of both the Commission and staff and urges additional physician involvement in the political process. The reference committee congratulates the Commission for the outstanding, comprehensive report which is indicative of lots of hard work and visionary thought, and recommends adoption of Report H. ¶Action: ADOPTED

● REPORT N—COMMITTEE ON SAFE TRANSPORTATION: The report outlines activities and upcoming plans of the Committee on Safe Transportation relative to driver training for physically handicapped persons, national developments in the field of medical aspects of highway safety, which are being followed, including the use of telescopic lens, the highway speed limit, and motorcycle helmet laws, and impending recommendations on blood alcohol testing, medical impairment reporting forms, intrastate commercial drivers, and legislation to provide immunity for physicians reporting on persons with driving impairment. The reference committee commends the Committee for its activities with the University of Wisconsin and the Division of Motor Vehicles; encourages development of its planned legislative recommendation, and recommends adoption of the report. ¶Action: ADOPTED

● REPORT Q—AD HOC COMMITTEE ON CHIROPRACTIC: Efforts by the committee to challenge attempts by chiropractors in Wisconsin to legislate themselves into the health field are summarized in Report Q. The reference committee commends the Ad Hoc Committee for its aggressive efforts and recommends approval of its report.
¶Action: ADOPTED

● RESOLUTION 12—*National Catastrophic Illness Insurance*: Recommends that the State Medical Society of Wisconsin direct the American Medical Association delegates to pass legislation asking Congress to pass a bill covering catastrophic illness in the next session. Your committee recommends that the Society endorse the principle con-

tained in legislation designed to provide health insurance coverage for catastrophic illnesses.

¶Action: Recommendation adopted in lieu of resolution

● RESOLUTION 13—*Public Law 93-641:* Recommends that the State Medical Society of Wisconsin support in spirit and principle the plaintiff action of the North Carolina Medical Society against HEW with regard to Public Law 93-641 Health Planning Act, an administrative law dealing with certificate-of-need and certain health systems agency regulations. Your committee recommends adoption of the resolution. ¶Action: ADOPTED

● RESOLUTION 14—*Public Law 93-641*: Recommends that the State Medical Society of Wisconsin call for repeal of PL 93-641, and oppose any substitute federal or state legislative measures which contain similar provisions for the solution of our health problems. Because of the recent action of the Council on certificate-of-need and given the desire of all of us here today to witness the repeal of PL 93-641, the reference committee suggests the deletion of the three words "or state legislative" on line two of the Resolve section of the resolution, amending it to read:

> *"Resolved,* That the State Medical Society of Wisconsin call for repeal of PL 93-641, and oppose any substitute federal measures which contain similar provisions for the solution of our health problems."

We feel this will maintain our position against PL 93-641 while at the same time avoid conflict on the state level.

¶Action: Resolution 14 adopted as amended

● RESOLUTION 16—*Title XIX Fee Freeze:* Recommends that the State Medical Society of Wisconsin continue its legal action against the State of Wisconsin in an attempt to prevent the continuance of the fee freeze for Title XIX patients. Your committee recommends adoption of the resolution. ¶Action: ADOPTED

● RESOLUTION 17—*Patients Compensation Fund*: Recommends that the State Legislature be asked to protect the monies collected via the Wisconsin Professional Liability Plan and the Patients Compensation Fund, and that they not be invaded for any extraneous purpose. Because Chapter 37, Laws of 1975, establishing these accounts already contains specific language protecting them from use for other purposes, the committee recommends deletion of "be asked to" from line one of the Resolve section of the resolution, amending it to read:

> *"Resolved,* That the legislature protect these monies for the specific purpose delineated, and that purpose alone, and that they not be invaded for any extraneous purpose."

This amendment would then recommend that the legislature continue to so protect the Plan and Fund.

¶Action: Resolution 17 adopted as amended

● RESOLUTION 18—*Medical Eye Care*: Recommends that the State Medical Society of Wisconsin reaffirm its policy that only physicians licensed to practice medicine and surgery in all of its branches are qualified to prescibe or apply eye medications, and that any attempts by nonmedical practitioners to engage in such practice through legislative or administrative rulings in the State of Wisconsin be vigorously and actively opposed at whatever level is appropriate in order to assure the continued welfare of the citizens of the State of Wisconsin in regard to any and all such matters. Your committee recommends adoption of the resolution. ¶Action: ADOPTED

● RESOLUTION 19—*Psychiatric Medical Services*: Recommends that the State Medical Society of Wisconsin affirm and support the standards of psychotherapy of the American Psychiatric Association, and vigorously oppose any attempt by psychologists or others, by legislation, to become primary providers of psychiatric medical care to the further detriment and fragmentation of man and society. Your committee recommends adoption of the resolution. ¶Action: ADOPTED

● RESOLUTION 26—*High Cost of Continuing Medical Education*: Recommends that the State Medical Society of Wisconsin investigate the factors involved in skyrocketing cost of medical meetings and implement an expanded program with the State of Wisconsin through the two Wisconsin medical schools to provide CME programs that are of good quality, practical, at reasonable cost and easily accessible to all of the physicians of Wisconsin. Your committee recommends adoption of the resolution.

¶Action: After floor discussion of the committee's recommendation to adopt the resolution, the motion lost and Resolution 26 was REJECTED

HOUGHTON MEDICAL STUDENT AWARD

Diana L Kruse and Daniel R Wartinbee

TWO SENIOR MEDICAL STUDENTS, Diana L Kruse of Wisconsin Dells and Daniel R Wartinbee of Waukesha received the State Medical Society's Houghton Award at the April Annual Meeting "for scholastic excellence, extracurricular achievement and interest in medical organization." The Houghton Award, given annually, honors a senior medical student from each of Wisconsin's two medical schools. The recipients are presented $100 and a plaque.

Ms Kruse received a bachelor's degree from the University of Wisconsin-Madison in 1973, and spent her first two years as an undergraduate on the Baraboo campus. Her work in medical school has been consistently above the class mean, and her excellence earned her election to Alpha Omega Alpha in her senior year. While in college, she was employed on a part-time basis, and also was active in a tutorial program for underprivileged children. Ms Kruse was elected president of her class in the senior year. She is a member of the Board of Directors of the Wisconsin Medical Alumni Association. She also was a student member of the steering committee appointed to direct the Institutional Self-Study Program as a part of the accreditation review process of the medical school. (Ms Kruse was unable to accept the presentation personally as she was participating in a trauma rotation at San Francisco General Hospital.)

Mr Wartinbee was born in LaCrosse, and has lived most of his life in Brookfield and Waukesha. He attended Brookfield Central High School and the University of Wisconsin-Madison. He was accepted to medical school after three years of undergraduate work.

The Houghton Award is given by the Society's Charitable, Educational and Scientific Foundation. The Foundation selects the student for his potential in becoming a "complete physician." The criteria include not only outstanding academic achievement, but active participation in medical school activities. The Houghton Award was established in 1968 by Dr John H Houghton, Wisconsin Dells, to emphasize high ideals for future physicians. Later, his brother, William, also a physician contributed to the fund. Both physicians are now deceased.

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

● RESOLUTIONS 1, 2, 3 and 4—*Unified Membership*: With reference to resolutions 1 through 4 dealing with unified membership, the recommendation of the committee is that 1, 2 and 3 [making AMA membership optional, abolishing the policy, or requiring a binding referendum of the membership] be rejected and that resolution 4 supporting unified membership be adopted. Recognizing the varied opinions on this matter in the grass roots, the committee recommends a roll call vote on the recommendation to adopt resolution 4 so that the constituents may know their delegates' stand on this crucial issue. We further recommend that the Society make a concerted effort in the ensuing year to educate the physicians of Wisconsin on the advantages of unified membership. The committee moved adoption of this portion of its report and requested a roll call vote.

¶Action: Several suggestions or amendments were defeated to divide the question; to vote separately on resolution 3; to delete the necessity for a roll call vote. A roll call vote was taken on the motion of the reference committee, which carried 87-41. [NOTE: At the direction of the Speaker of the House of Delegates, a copy of the roll call vote has been sent to the president of each county medical society and specialty section chairman. It will also appear in the transcript of the proceedings on file at the State Medical Society.]

● RESOLUTION 5—*Multiple Office Holding*: Recommends that "it shall be the policy of the State Medical Society of Wisconsin that no member shall serve concurrently as a constitutional officer of the Society and as a delegate or alternate delegate to the American Medical Association." Your committee recommends adoption as written. ¶Action: ADOPTED

● RESOLUTION 6—*Nominations for President (elect) of the State Medical Society*: Your committee recommends rejection of this resolution requesting submission of at least two nominees by the nominating committee.

¶Action: Resolution 6 REJECTED

AMA DELEGATE RECOGNITION AWARD

John M Bell, MD

DR JOHN M BELL (right), Marinette, received the AMA Delegate Recognition Award at the Society's Annual Meeting held in Milwaukee on April 14. Doctor Bell had served as a delegate to the AMA from 1964-1976. He was presented with a silver tray signed by the other delegates to the AMA from the Society. Dr Henry Twelmeyer of Wauwatosa, chairman of the Wisconsin delegation to the AMA, presented the tray. In recognition of retiring delegates, the award was first presented to Dr Ervin L Bernhart, Milwaukee, in 1972. Other physicians who have received the award are: Dr Charles J Picard, Superior; Dr Roman E Galasinski, Milwaukee; and Dr William B Hildebrand, now deceased.

WISCONSIN'S AMA DELEGATES, shown at right during the Winter Clinical Congress in Philadelphia, will have a caucus in early June to discuss AMA matters in preparation for the AMA Annual Meeting, June 18-22, in San Francisco. Delegates caucus periodically between AMA sessions. Their input at these sessions is highly respected and fully recognized by other state delegations. Dr John Dettmann of Green Bay, a new delegate this year, has been named to the AMA reference committee on constitution and bylaws. Delegates welcome communications from the membership. A list of delegates and alternates appears annually in the June BLUE BOOK issue of the **Wisconsin Medical Journal.**

BEAUMONT MEMORIAL LECTURE AWARD

Robert Zeppa, MD

ROBERT ZEPPA, MD, Miami, Fla, received the 1977 William Beaumont Memorial Lecture Award for his Annual Meeting presentation, "Portal Hypertension." Doctor Zeppa, Professor and Chairman, Department of Surgery, University of Miami, gave his lecture at the scientific plenary surgery session in Milwaukee April 16.

The William Beaumont Memorial Lecture Award is given to an outstanding surgeon. It was established in 1957 by the State Medical Society Council to memorialize Dr William Beaumont, an 18th Century pioneer in digestive studies.

Presenting the award was Dr L C Pomainville, Wisconsin Rapids, Society historian and treasurer of the Society's CES Foundation, which administers the Beaumont Memorial Fund.

ELVEHJEM MEMORIAL LECTURE AWARD

Andre J Nahmais, MD

IN MEMORY of Conrad A Elvehjem, PhD, 13th president of the University of Wisconsin-Madison, the Charitable, Educational and Scientific Foundation of the State Medical Society established a memorial lecture. This year's Elvehjem lecture was given by Dr Andre J Nahmais, Professor and Chief, Infectious Disease and Immunology Division, Emory University School of Medicine, Atlanta, Ga. Doctor Nahmias's presentation "Herpes Virus: Epidemiology, Genital Lesions, Relation to Cancer—Diagnosis and Treatment of Herpes Infection," was given at the plenary session in conjunction with the Annual Meeting of the State Medical Society in Milwaukee on April 16. Dr Daniel K Schmidt, CES Foundation trustee, presented the plaque.

● RESOLUTION 20—*Electromyoneurographic Procedures and Examinations*: The committee recommended adoption of the resolution as follows (whereases omitted here):

> *"Resolved,* That clinical electromyoneurographic procedures and examinations which inherently involve medical interpretations, description of findings, and rendering of diagnostic opinions, be performed only by physicians licensed to practice medicine and trained in these procedures; and be it further
>
> *"Resolved,* That the State Medical Society of Wisconsin request the State Board of Medical Examiners to investigate and take appropriate action in all cases involving the performance of electromyoneurographic examinations by persons who are not physicians licensed to practice medicine in all its branches."
>
> ¶Action: ADOPTED

● RESOLUTION 21—*Telephone Transmission of Electroencephalograms*: Your committee recommends adoption as presented (whereases omitted here):

> *"Resolved,* That the State Medical Society of Wisconsin endorses the position of the Wisconsin Neurological Society recommending that:
>
> 1. (a) The recording/transmitting technologist be at least as competent as the receiving technologist.
> (b) There should be an original EEG recorded at the transmitting site.
> (c) The record should be adequately identified as to patient identification, changes in instrument controls, calibrations, montages, and patient behavior activity.
> 2. The minimum technical requirements for telephone EEG transmission should consist of:
> (a) The apparatus should be of such design as to enable the above three criteria to be fulfilled.
> (b) Voice or other signalling provided for identification of changes as they occur with minimal interference with the EEG record.
> (c) The telephonic transmission system should meet the frequency response criteria of Paragraph 5.4 in AES Guidelines #2.
> (d) The system should be capable of providing hard copy at the transmitting site."
>
> ¶Action: ADOPTED

● RESOLUTION 22—*Physician Extenders, "Independent Practitioners," and Point of Entry into Health Care System:* Your committee recommends adoption, as follows (whereases omitted here):

> *"Resolved,* That appropriate committees of the State Medical Society of Wisconsin continue to monitor closely Physician Assistants and other extenders to assure proper supervision and delegation of responsibility; and be it further
>
> *"Resolved,* That vigilance be maintained to make certain that 'Physician Extenders,' and any 'Independent Practitioners,' function in accordance with applicable statutes; and be it further
>
> *"Resolved,* That the State Medical Society of Wisconsin reaffirm its conviction that patients are well advised to enter the health care system through physicians, best prepared to diagnose disease, best prepared to develop a plan of treatment, and best situated to coordinate the efforts of the several professionals involved in the care of a patient."
>
> ¶Action: ADOPTED

● RESOLUTION 23—*Hospital Emergency Unit Abuses:* Your committee agrees with the purpose of the resolution, but because of fiscal implications, recommends that it be referred to the Council for consideration of the feasibility of its full implementation. ¶Action: Referred to Council

● RESOLUTION 24—*Hospital Medical Care Costs:* Your committee studied resolution 24 and recommends that it not be adopted, but returned to the Fond du Lac County Medical Society to be rewritten for clarification and resubmitted at a later time.

¶Action: Resolution rejected and returned to author

● RESOLUTION 27—*Home Health Care*: Your committee recommends adoption as follows (whereases omitted here):

> *"Resolved,* That the State Medical Society of Wisconsin not only reaffirm the traditional values in home care, but also actively develop new initiatives in cooperation with other interested parties to promote a wider utilization of the concept of home health care."
>
> ¶Action: ADOPTED

● RESOLUTION 28—*Depilatron Method of Hair Removal:* Your committee recommends adoption as follows (whereases omitted here):

> *"Resolved,* That the State Medical Society of Wisconsin go on record as not recommending or approving the use of the Depilatron method for permanent hair removal."

¶Action: ADOPTED

● COUNCIL SPECIAL REPORT 3—*Bylaw Amendment on Election of Officers*: This proposes amendment of Section 3, Chapter IV of the Bylaws relating to procedures for election of officers and delegates and alternates to the American Medical Association. Your committee recommends adoption of the proposed revision, as follows:

> SEC. 3. The House of Delegates shall elect the president-elect, speaker and vice-speaker of the House of Delegates, and delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the legal votes cast shall be necessary to elect. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie for the lowest number of votes and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

¶Action: ADOPTED

● SUPPLEMENTARY REPORT OF COUNCIL—*Item 2 on Creation of Special Section*: Your committee recommends approval of the creation of a specialty section on emergency medicine. ¶Action: ADOPTED

REFERENCE COMMITTEE ON FINANCES

● RESOLUTION 8—*Wisconsin Physicians Service*: Your committee heard testimony on this resolution and later discussed it in executive session. Since the separate incorporation of WPS is mandated by Wisconsin law and is nearly accomplished, this will have the same basic effect as the resolution suggests. Your committee therefore recommends this resolution be rejected.

¶Action: Resolution REJECTED

● COUNCIL SPECIAL REPORT 1—*Wisconsin Physicians Service*: On the same basic subject of the separate incorporation of WPS, your committee considered Council Special Report 1. We acknowledge receipt of this report and recommend it be filed. Furthermore, we encourage the Council to continue its efforts until this matter is completed. ¶Action: Report FILED

● RESOLUTION 9—*Blue Plans*: In the testimony and subsequent discussion, it became evident that the SMS can encourage the Blue Plans to administer the usual, customary, reasonable fees concept in its original intent, but it should not, nor can it, be put in a position of negotiating any type of a statewide fee schedule, whether it be with the Blue Plans or any other insurance company. This must be accomplished on an individual physician or local level. On this basis we recommend Resolution 9 be rejected.

¶Action: Resolution REJECTED

● RESOLUTION 10—*Psychiatric Medical Services Insurance*: We heard considerable testimony on this resolution and had even more discussion while in executive session. Testimony indicated the intent of the resolution was to establish a State Medical Society position that would encourage insurance companies to include such services in Major Medical portions of health insurance policies. On the basis that the Council and WPS Commission "approved offering a Major Medical contract to all groups which included identical benefits for the services of all physicians in place of the then current contract which contained, in some instances, a co-insurance for psychiatric services" on September 27, 1975, your committee feels the action intended by this resolution has already been taken and on that basis recommends this resolution be rejected. ¶Action: Resolution REJECTED

CIVIC LEADERSHIP AWARD

George H Handy, MD

DR GEORGE H HANDY (right), Madison, received the Civic Leadership Award at the Society's April Annual Meeting. The award, the sixth time it has been given, was presented to Doctor Handy by outgoing Society president, Dr Charles J Picard of Superior. "Doctor Handy's many activities identify him as not only a dedicated physician but a dedicated public servant—and most significantly, one who practices personal involvement in the democratic processes of this great republic," Doctor Picard quoted from the plaque. Doctor Handy was licensed to practice in Wisconsin in 1947, and until 1964 was in general practice in Wisconsin Rapids. In 1965 he received his degree in public health from the University of Minnesota. For the next two years he was a resident in preventive medicine under the State Board of Health in Madison, and in 1967 was named an assistant clinical professor at the University of Wisconsin Medical School. Since 1967, he served as director of the Bureau of Comprehensive Health Planning in the State Division of Health, until the transfer of the program in January 1973. He was administrator of the Division of Health and State Health Officer from 1971 to 1976, when he resigned to take a position with the Cuna Mutual Insurance Company in Madison. In 1973 he was elected president of the Conference of State and Provincial Health Authorities of North America.

● RESOLUTION 11 — *Office Surgical Procedures Insurance*: While there was not much testimony, we did thoroughly discuss this in executive session. We recommend that Resolution 11 be adopted and referred to the Council for clarification and implementation.

¶Action: Resolution ADOPTED and referred to Council

● TREASURER'S REPORT: The report of the Society's Treasurer, Eugene J Nordby, MD, was discussed. We acknowledge the overall improved financial condition of the Society's General Fund and encourage the Council to continue its supervision of financial matters. We thank Doctor Nordby for the informative report and recommend that the Treasurer's Report for 1976 be received. (See financial statements elsewhere in this issue.)

¶Action: ACCEPTED

● WPS ANNUAL REPORT: The committee reviewed the 1976 report of WPS and wishes to acknowledge the improved financial position of this division of the Society, and recommends the WPS Annual Report be received.

¶Action: RECEIVED

● 1977 SMS BUDGET: Your committee reviewed this rather lengthy document and recommends its adoption.

¶Action: ADOPTED

● 1978 DUES: Current and future years' operating budgets go hand in hand with the establishment of dues. Your committee is aware of the 1975 House action which directed "future years' dues are to be adjusted annually so as to recognize the inflationary effect on the Society's budget." It further recognizes that since that time the combined inflationary rate exceeds 13% and that there has been no dues adjustment since 1976. After considering these factors and others, we recommend the 1978 State Medical Society dues remain the same as they were in 1976 and 1977 ($300). ¶Action: ADOPTED

OTHER ACTIONS

● *Standing Rule 4.a.*: This rule, which has been adopted in numerous previous sessions, reads: "An alternate delegate is alternate for a specific regular delegate and cannot serve as a 'roving' alternate delegate." Speaker Stuff moved this rule be changed to provide that an alternate delegate be designated as an alternate for any regular delegate within one's assigned State Medical Society district or specialty section. The motion was seconded. After discussion, including questions of legality of an alternate representing other than his own county medical society, the motion was amended by Doctor Natoli (La Crosse County) to refer it to the Council for study and presentation at the next annual session; seconded and carried.

● *Title XIX Provider Contract*: Past President Derus requested information for the delegates concerning the requirement that the State Department of Health and Social Services enter into written contracts with providers of care under Title XIX. Jordon Frank, MD (Rock County) presented a detailed report of the status of negotiations on the provider contract and other aspects of Medicaid in Wisconsin.

● *Speaker Patricia J Stuff MD*: By standing ovation, the House unanimously adopted a resolution introduced by Doctor Sahs of Sawyer County in appreciation of her admirable conduct of the sessions of the House of Delegates the past three years. ■

SPEAKER PATRICIA J STUFF, MD of Bonduel was presented a bouquet of roses in appreciation of her admirable conduct of the House of Delegates sessions over the past three years.

THANK YOU!

The committees of the House of Delegates are to be commended for their thoughtful deliberations and thanked for a job "well done." Committees are as follows:

Reference Committee on Reports of Officers: MDs Cornelius A Natoli, LaCrosse, chairman; Raymond R Watson, Milwaukee; John G Albright, Madison; Kenneth M Smigielski, Milwaukee; and Robert M Senty, Sheboygan.

Reference Committee on Reports of Standing Committees: MDs Robert A Starr, Viroqua, chairman; John Riesch, Menomonee Falls; Lloyd P Maasch, Weyauwega; Elmer E Johnson, Madison; and Gilbert H Stannard Jr, Manitowoc.

Reference Committee on Resolutions and Amendments to the Constitution and Bylaws: MDs William E Wright, Mondovi, chairman; Merne W Asplund, Bloomer; Bahri O Gungor, Neillsville; Milfred A Cunningham, Madison; and Robert F Madden, Milwaukee.

Reference Committee on Finances: MDs Joseph M Jauquet, Ashland, chairman; Jordon Frank, Beloit; Robert L Johnson, Wisconsin Rapids; William E Martens, Wauwatosa; and Harry R Foerster Jr, Milwaukee.

Committee on Credentials: MDs Vernon M Griffin, Mauston, and George F Flynn, Milwaukee.

PATRICIA J STUFF, MD
Speaker

Elections: House of Delegates, Council

The House of Delegates elected (or reelected) the following physicians to these positions:

PRESIDENT-ELECT:
Jules D Levin, MD, Milwaukee

SPEAKER:
Albert J Motzel Jr, MD, Waukesha (two-year term)

VICE-SPEAKER:
Duane W Taebel, MD, LaCrosse

AMA DELEGATES (1978-1979):
Gerald J Derus, MD, Madison
Henry F Twelmeyer, MD, Wauwatosa
(both reelected)

AMA ALTERNATE DELEGATES
Patricia J Stuff, MD, Bonduel (1977-1978) (unexpired term of the late Francis Lohrenz, MD)
Leo Grinney, MD, Racine (1977, unexpired term of Doctor Levin), (1978-1979)
John K Scott, MD, Madison (1978-1979) (reelected)

COUNCILORS:
District 1
Carl S L Eisenberg, MD, Milwaukee
Elizabeth Steffen, MD, Racine (unexpired term of William J Madden, MD, 1978)
District 3
Cornelius A Natoli, MD, LaCrosse
District 4
John J Kief, MD, Rhinelander
Russell F Lewis, MD, Marshfield
(both reelected)
District 5
Timothy T Flaherty, MD, Neenah
District 6
Antoine Barrette, MD, Peshtigo
District 7
Paul S Haskins, MD, River Falls (reelected)

The Council elected (or reelected) the following physicians to these positions:

CHAIRMAN OF THE COUNCIL:
Paul S Haskins, MD, River Falls

COUNCIL VICE-CHAIRMAN:
Richard W Edwards, MD, Richland Center (reelected)

SECRETARY AND GENERAL MANAGER of the Society:
Earl R Thayer, Madison (reelected)

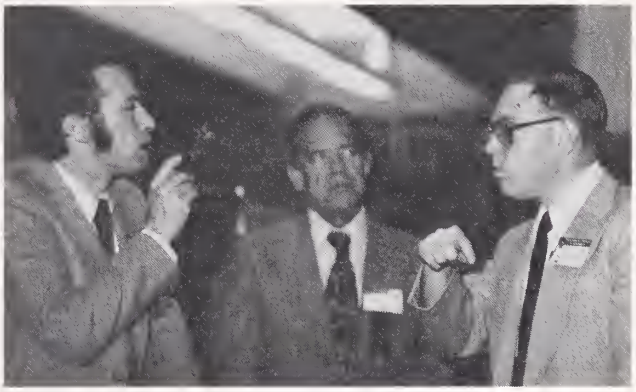
TREASURER of the Society:
Eugene J Nordby, MD, Madison (reelected)

ASSISTANT TREASURERS
Abraham A Quisling, MD, Madison
H Kent Tenney, MD, Madison
(both reelected)

WISCONSIN MEDICAL JOURNAL:
Editorial Director
Raymond Headlee, MD, Elm Grove (reelected)
Editorial Associates
Wayne J Boulanger, MD, Milwaukee
John P Mullooly, MD, Milwaukee
Leslie G Kindschi, MD, Monroe
T H McDonell, MD, Waukesha
Philip J Dougherty, MD, Menomonee Falls
Raymond A McCormick, MD, Green Bay
(all reelected)

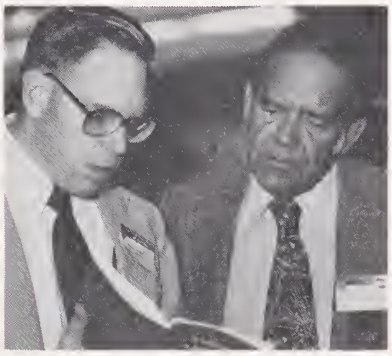
A full list of appointments to committees and commissions of the Society will appear in next month's BLUE BOOK issue of the *Wisconsin Medical Journal*. That issue will contain a complete listing of all Society officers and committee/commission members. ■

Annual Meeting Photos by Ken Opin



WALTER McCLURE, PhD (left) of Inter-Study in Excelsior, Minn and Carl Eisenberg, MD, a new councilor from Milwaukee, discuss the country's medical cost problems while new president, Dr Roy B Larsen, looks on. Doctor McClure spoke at the socioeconomic luncheon during the April Annual Meeting, outlining some major options for overhauling the medical system in terms of cost containment, levels of care, and levels of services. Major portions of his remarks will appear in the June BLUE BOOK issue.

RALPH ANDREANO, PhD (left), administrator of the State Division of Health, Department of Health and Social Services, and Earl Thayer, secretary of the State Medical Society, exchange viewpoints during a break in a House of Delegates session at which Doctor Andreano addressed delegates.



NEW COUNCILOR Carl Eisenberg, MD (left) of Milwaukee and new president Roy B Larsen, MD of Wausau.

See Financial Statements following page

THE FOLLOWING FINANCIAL STATEMENTS are a part of the Annual Certified Audits prepared by Donald E Gill & Company, certified public accountants, and reflect the general financial condition of the Society at December 31, 1976. ■ Audit reports were prepared for the State Medical Society of Wisconsin and its related organizations: State Medical Society of Wisconsin (General Fund), Wisconsin Medical Journal, Wisconsin Physicians Service, Civilian Health and Medical Program of the Uniformed Services, Supplemental Medical Insurance Benefits for the Aged, SMS Realty Corporation, Charitable, Educational and Scientific Foundation, Inc., and Revised Employees' Pension Plan and Trust Agreement. ■ These reports, in their entirety, may be reviewed by members upon request to the State Medical Society office.

STATE MEDICAL SOCIETY OF WISCONSIN
General Fund
Madison, Wisconsin
BALANCE SHEET
December 31, 1976

ASSETS		
Current Assets		
Cash		$ 244,293.98
Accounts Receivable—General		135,717.51
Employee Travel Advance		3,650.00
Due from Charitable, Educational and Scientific Foundation, Incorporated		6,675.33
Due from SMS Realty Corporation		2,298.83
Due from Employees Pension Plan		2,131.83
Due from Wisconsin Medical Journal	$134,766.41	
Investment in Wisconsin Medical Journal (Deficit)	(111,035.28)	23,731.13
Due from Other Divisions and Related Organizations for Accrued Payroll and Vacation Pay		564,479.59
Certificates of Deposit		300,000.00
Commercial Paper		590,289.58
Common Stock at Cost (Market Value $10,916.25		8,361.52
Accrued Interest Receivable		1,109.77
Dividends Receivable		55.35
Guarantee Deposits		425.00
Prepaid Postage and Deposit		21,275.29
Prepaid Insurance		388.80
Office Supplies Inventory		3,314.16
Printing and Forms Inventory		9,568.18
Deferred Expense		2,225.00
Prepaid Rent and Service		11,657.00
Total Current Assets		$1,931,647.85
Fixed Assets		
Furniture and Equipment	$105,871.21	
Less: Accumulated Depreciation	58,635.65	
Total Fixed Assets		47,235.56
TOTAL ASSETS		$1,978,883.41
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable		$ 46,756.25
Due Wisconsin Physicians Service		185,111.71
Dues Held for Milwaukee Auxiliary		4,541.00
Dues Held for Section on Ophthalmology		14,647.63
Accrued Payroll Taxes		29,900.14
Other Payroll Deductions		1,405.71
Unapplied Membership Dues		6,634.50
Accrued Property Taxes		1,642.39
Use Tax Payable		140.53
Accrued Payroll and Vacation Pay		622.272.44
Retirement Plan Contribution Payable		70,499.48
Total Current Liabilities		$ 983,551.78
Deferred Income		
Prepaid Membership Dues	$843,496.50	
Other Prepaid Income	8,500.00	
Total Deferred Income		851,996.50
Total Liabilities		$1,835,548.28
NET WORTH		
Capital of General Fund, January 1, 1976	($ 25,530.35)	
Income Over Expense—1976 Operations	188,053.01	
Expense Over Income—1976 Special Assessment	(3,781.56)	
Increase (Decrease) in Capital Invested in Wisconsin Medical Journal	(15,405.97)	
Total Capital, December 31, 1976		143,335.13
TOTAL LIABILITIES AND CAPITAL		$1,978,883.41

STATE MEDICAL SOCIETY OF WISCONSIN
General Fund
Madison, Wisconsin
STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1976

INCOME		
Members 1976 Dues		$1,161,928.50
Less: Allocation to Wisconsin Medical Journal		19,385.00
Balance		$1,142,543.50
Members Dues—Prior Years		2,356.90
Income on Funds Invested		29,121.56
Miscellaneous Income		42.70
Gain on Sale of Fixed Assets		25.00
AMA Grant for Study of Health Care in Correctional Institutions		25,000.00
TOTAL INCOME		$1,199,089.66
EXPENSES		
Payroll		$ 441,778.12
Payroll Related Costs		98,315.36
President and President-Elect Travel		5,875.45
AMA Annual Clinic and Special Meetings		12,000.00
Conference Expenses		33,940.84
Association Dues		3,067.40
Travel Expenses		78,589.00
Telephone		29,509.90
Resource Material		2,857.70
Printing and Forms		37,721.36
Postage		29,108.97
Promotion		40.00
Insurance—General		7,727.65
Grants and Appropriations		7,500.00
Cafeteria Expense		2,782.76
Speakers Expense		4,406.70
Outside Services		78,550.35
Office Services		53,342.60
Miscellaneous Expense		3,687.24
Accounting Service		4,193.54
Legal Counsel		65,209.04
SMS Legislative Retainer		17,106.33
Depreciation		3,541.71
Rent—Central Office		61,276.89
Personal Property Taxes		1,642.39
Total		$1,083,771.30
Less Portion of Above Expenses Recovered by Services Furnished to Others		58,691.29
NET EXPENSES		$1,025,080.01
Excess Income Over Expense Before *Wisconsin Medical Journal* and SMS Realty Corporation		$ 174,009.65
SMS Realty Corporation Distribution of 1975 Income	$12,121.27	
Less State Medical Society Donation to Capital of SMS Realty Corporation	1,859.47	10,261.80
Subtotal		$ 184,271.45
Loss Per *Wisconsin Medical Journal* Statement of Income and Expense		15,405.97
General Fund Excess Income Over Expense		$ 168,865.48

EDITOR'S NOTE: Notes accompanying the foregoing statements in the original Certified Audit are not included here because of space limitations. ■

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COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

March 5, 1977 — Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Correll at 10 am on Saturday, March 5, 1977, at the State Medical Society.

Voting members present: Chairman Correll, Vice-chairman Edwards; Doctors Boulanger, Schmidt, Bruhn, LaBissoniere, Huth, Crowley, Edwards, Tuftee, Waterhouse, Rohde, Kief, Lewis, Peters, Smejkal, Haskins, Doyle, Picard, Larsen, and Motzel.

Others present (part or entire): Doctors Nordby, Lubitz, Kabler, Marc Hansen; Drs Hildegard Siegel and Karen Pridham; Messrs Thayer, Maroney, Simms, Jensen, Nelson, Brower, Fetherston, Wendle, Opin, Stromer; Mmes Bartel and Price-Marcus; Miss Pyre.

2. Approval of Minutes

On motion of Doctors Picard-Waterhouse, carried, minutes of the January 15, 1977, meeting were approved.

3. Joint Practice Guidelines

Doctor Correll reviewed the circumstances requiring reconsideration of the Council action in January in reference to the guidelines developed by the Joint Practice Committee in elaboration of the joint practice statement approved by the Council in 1974 and by the House of Delegates in 1975.

There was considerable discussion in which several councilors questioned the need for anything other than the joint practice statement, and whether the proposed supplement constituted true guidelines. Others spoke to the value of the proposed guidelines to those involved or interested in a joint practice situation.

On motion of Doctors Edwards-Huth, carried, the Council accepted the guidelines as a document under continuing development in implementation of the joint practice statement, subject to ongoing study and refinement by the Joint Practice Committee, with report to the Council as necessary.

4. Certificate of Need

Mr Jensen made a detailed presentation of federal health planning requirements; analysis of certificate-of-need laws enacted in 32 states; comparative summary of current major proposals to the Wisconsin Legislature; and recommendations of the Commission on Governmental Affairs as to a Society position in negotiations on certificate-of-need legislation to be enacted in the 1977 session.

On motion of Doctors Waterhouse-Lewis, carried unanimously, the Council approved the following elements of an acceptable certificate-of-need bill:

a. Exemption of physicians' offices from the definition of "health care institution" for purposes of certificate-of-need and service licensure.

b. Certificate-of-need for a physician's office would be required only in the event that the physician had intentions of purchasing or leasing a single piece of diagnostic or therapeutic equipment which exceeds $150,000 in cost, or $250,000 for two or more items of equipment, with the burden of proof upon the State as to medical necessity of such a purchase or acquisition.

c. That these capital equipment expenditure "thresholds" be subject to an inflationary factor.

d. That physicians' offices not be covered through a change in service test.

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e. That there be no extension of coverage for a given number of years.

f. That there be ongoing study of the effectiveness of certificate-of-need.

g. That the legislation have a self-destruct (sunset) provision after a given number of years.

h. That there be provision for appeal to a body other than the Secretary of the Department of Health and Social Services.

i. That there be no DHSS rules applicable to review of projects under the capital expenditure "threshold."

In the motion, the first four items were considered essential, with the possible exception of the amount of the "threshold," and the last five were considered highly desirable.

Doctor Schmidt asked for withdrawal of Resolution 15 from the Medical Society of Milwaukee County concerning certificate-of-need.

Doctor Correll informed the Council of a recent communication addressed to it by Senator Offner and Representatives Flintrop and Czerwinski, asking that the Society "identify or appoint a group of your members" to represent its interests on certificate-of-need and service licensure.

On motion of Doctors Rohde-Edwards, carried, the Council approved a reply naming the Society's legislative coordinators, Messrs Brian Jensen and Doug Nelson; and further, authorized the President, President-elect, Chairman of the Council, and Chairman of the Commission on Governmental Affairs to deal with any policy questions that may arise.

5. WPSIC

Mr Thayer outlined minor changes in the Articles and Bylaws and other agreements reached in negotiations with the Insurance Commissioner concerning the application for incorporation of WPS, as follows:

a. The public members of the Board of Directors, one less than half, shall not include any employee of the corporation.

b. No more than 15% of the total number of directors shall be members of the Council.

c. Directors may be removed for cause by a 2/3 vote—formerly with or without cause by majority vote.

d. Nominating Committee of the Council shall include on the slate of nominees to the Council for election to the board representatives of certain groups named as examples—formerly discretionary.

e. WPS agrees to continue its efforts to contain costs, to commit budget to that activity and report annually to the Commissioner.

f. WPS agrees to establish a policyholders' committee within 15 months of incorporation.

On motion of Doctors Huth-Schmidt, carried, these amendments and agreements were ratified by the Council.

On motion of Doctors Schmidt-Huth, carried, the Council adopted the following resolution relative to a special audit:

Resolved, That as a matter of prudent management and to safeguard the respective interests of the Society, WPSIC, the state and federal governments and creditors, the Council direct that an adequate audit be made covering all property, tangible and intangible, which is to be transferred to WPSIC by SMS acting for its Division, WPS, the date of such audit to be that as of which WPSIC is authorized to begin business; and be it further

Resolved, That the Chairman of the Finance Committee, and the Secretary of the Society be authorized after appropriate consultation to determine the minimum scope of such audit and to designate the firm of independent certified public accountants to conduct such audit; and be it finally

Resolved, That the cost of such audit be borne by WPSIC.

6. Donald E Gill

On motion of Doctors Huth-Smejkal, carried, the following memorial resolution was adopted:

WHEREAS, Donald E Gill, Madison, served as the consulting certified public accountant for the State Medical Society of Wisconsin from 1948 to the time of his death in February 1977; and

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WHEREAS, His business and financial counsel during those years was invaluable to the development of the Society and more especially its insurance arm, Wisconsin Physicians Service, the SMS Realty Corporation, and the Charitable, Educational and Scientific Foundation of the Society; therefore be it

Resolved, That the Council of the State Medical Society record its esteem for Donald E Gill and his talented and dedicated service to the Society and its members, and at the same time convey through this resolution its sincere sympathy to his wife, Mary, and other members of the family.

7. Miscellaneous

Councilors were reminded to submit nominations for commissions and committees, and to set dates for district caucuses.

8. Adjournment — 12:10 pm.

EARL R THAYER
Secretary

Approved: April 13, 1977
HOWARD L CORRELL, MD
Chairman

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MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of March 30, 1977

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

BARRON-WASHBURN-BURNETT

Beehner, Michael L, Rte 2, Box 45, Rice Lake 54868 (1945, Regular, General Practice/General Surgery)

CLARK

Reddy, R V, 216 Sunset Place, Neillsville 54456 (1945, Regular, Pediatrics)

COLUMBIA-MARQUETTE-ADAMS

Guzman, Victor C, Jr, 1512 New Pinery Rd, Portage 53901 (1929, Regular, General Practice/Obstetrics and Gynecology)

FOND DU LAC

Veit, Kirk A, 80 Sheboygan St, Fond du Lac 54935 (1944, Regular, Pediatrics)

JEFFERSON

Shannon, Gordon J, 123 Hospital Dr, Watertown 53094 (1931, Regular, General Surgery/Cardiovascular Surgery, Certified-GS)

Song, Moon-Won, 123 Hospital Dr, Watertown 53094 (1938, Regular, Obstetrics and Gynecology, Certified)

KENOSHA

Ali, M Yusuf, 3618 8th Ave, Kenosha 53140 (1937, Regular, Internal Medicine)

Romani, Frank V, 3618 8th Ave, Kenosha 53140 (1939, Regular, Internal Medicine)

LaCROSSE

Brubaker, Stephen J, 1836 South Ave, LaCrosse 54601 (1944, Regular, Ophthalmology, Certified)

Rho, David Seungwod, 2905 Farnam St, LaCrosse 54601 (1937, Regular, Anesthesiology, Certified)

MILWAUKEE

Atkinson, W T, Jr, 10247 W National Ave, Milwaukee 53227 (1929, Regular, Pediatrics, Certified)

Ho, Khang-Cheng, 8700 W Wisconsin Ave, Milwaukee 53226 (1940, Regular, Neurology, Certified-P)

Karos, Michael G, 4359 S Howell Ave, Milwaukee 53209 (1933, Regular, Anesthesiology)

Knechtges, Thomas E, 2900 W Oklahoma Ave, Milwaukee 53215 (1944, Regular, Diagnostic Radiology/Radiology, Certified-R)

Patel, Kita D, 5000 W National Ave, Wood 53193 (1946, Regular, Anesthesiology)

Pisciotta, Anthony V, 8700 W Wisconsin Ave, Milwaukee 53226 (1921, Regular, Internal Medicine, Certified)

Reminga, Thomas A, 2025 E Newport Ave, Milwaukee (1947, Regular, Emergency Medicine)

Schmitt, Karl W, 2900 W Oklahoma Ave, Milwaukee 53215 (1943, Regular, Pathology, Certified)

Shirke, Shaila R, 5615 W Hampton Ave, Milwaukee 53218 (1934, Regular, General Practice)

OUTAGAMIE

Austin, Robert J, 401 N Oneida St, Appleton 54911 (1946, Regular, Obstetrics and Gynecology)

ROCK

Rowe, David S, 2020 E Milwaukee St, Janesville 53545 (1942, Regular Otorhinolaryngology, Certified)

SAUK

Singh, Harjeet M, 1900 Dewey Ave, Reedsburg 53959 (1937, Regular, Family Physician/General Surgery)

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WAUKESHA

Lochen, Gregory R, 8501 Jackson Park Blvd, Wauwatosa 53226 (1946, Regular, Ophthalmology)
Reinke, Frederick E, W180 N7950 Townhall Rd, Menomonee Falls 53051 (1944, Regular, Internal Medicine, Certified)
Wagner, Robert S, 39640 Mary Lane, Oconomowoc 53066 (1946, Regular, Internal Medicine/Gastroenterology, Certified-IM)

WINNEBAGO

Hoehne, Kurt A, 1841 Northpoint St, Oshkosh 54901 (1911, Regular, Psychiatry/Internal Medicine)

CHANGE OF ADDRESS

(Does not include those within o city)

County Medical Society

ASHLAND-BAYFIELD-IRON

Edwards, Paul K, Kaneohe, HI, to PO Box 37, Iron River 54847

BROWN

Hable, Jane, Green Bay, to 20A Jane Lacy Rd, Endicott, NY 13760

LoCROSSE

Henke, Timothy K, LaCrosse, to 5694 Monticello Way, Madison 53719

MILWAUKEE

Galasinski, Roman E, Milwaukee, to Clearwater Lake, Oneida County 54518
Kijner, Herry H, Milwaukee, to 3731 North Park Rd, Hollywood, FL 33021
Landis, Ralph V, Milwaukee, to 210 North Park Ave, Appleton 54911

WASHINGTON

Murphy, James A, West Bend, to 4334 Stonecrest Dr, St Joseph MO 64506

DEATHS

Spelbring, Paul G, Eau Claire-Dunn-Pepin County, Apr 8, 1976
Allen, Judson S, Monroe County, Feb 21, 1977
Rueckert, Ray R, Columbia-Marquette-Adams County, Feb 25, 1977
Mountain, David C, Milwaukee County Mar 20, 1977
Blanchard, Porter B, Ozaukee County, Mar 22, 1977. ■

OBITUARIES

◈County, State, AMA Members

◈ **Paul Greenwood Spelbring, MD,** 81, Eau Claire, died Apr 8, 1976 in Eau Claire. Born Sept 21, 1895 in Salem, Neb, Doctor Spelbring graduated from Rush Medical College, Chicago, in 1927. He had been a member of the medical staff of Luther and Sacred Heart hospital, Eau Claire, until his retirement in 1969.

◈ **Robert D DeCock, MD,** 62, Appleton, died Jan 24, 1977 in Appleton. Born Jan 25, 1914 in Angelica, Wis, Doctor DeCock graduated from Marquette University School of Medicine in 1940. Doctor DeCock, an ophthalmologist, had practiced in Appleton since 1947. He had served on the medical staffs of St Elizabeth and Appleton Memorial hospitals. Surviving are his widow, Chris; three sons, David G, MD, Wauwatosa; Dennis R, Chicago; and Richard D, at home.

◈ **Thorn L Vogel, MD,** 73, retired Janesville Health Commissioner and former Milton physician, died Feb 9, 1977 in Janesville. Born Nov 28, 1903 in Milwaukee, Doctor Vogel graduated from the University of Wisconsin Medical School in 1928. Doctor Vogel retired from general practice in 1958. He studied at the University of Indiana and the University of Michigan, receiving a master's degree in public health. He served as health officer in Janesville from 1962 until retiring in 1971. Prior to his death, Doctor Vogel had published an autobiographical book entitled "Woebegone" which was reported in the April 1977 issue of the *Wisconsin Medical Journal*.

Surviving are his widow, Mitzi; three sons, Richard, Janesville; Thomas, East Lansing, Mich; Gerald, Washington, DC; and a daughter Mrs Nancy Fink, New Berlin.

◈ **Raymond R Rueckert, MD,** 70, retired Portage physician, died Feb 25, 1977 in Portage. Born July 1, 1906 in Portage, Doctor Rueckert graduated from the University of Wisconsin Medical School in 1939 and practiced in Portage from 1956 until his retirement in 1974. He also served as medical director of Columbia County Hospital and Nursing Home. Doctor Rueckert was an assistant professor of Preventive Medicine at the University of Wisconsin, and was on the staff of the University Health Service. He was the physician for the University of Wisconsin crew and also on the medical staff of the University of Wisconsin Hospitals. Doctor Rueckert served in the United States Navy as a Lt Commander in World War II and was stationed at base hospitals in the South Pacific area. He served on the State Medical Society's Commission on Medical Care Plans from 1968-1974.

Surviving are his widow, Dorothy; two daughters, Mrs Kenny (Gretchen) Hepler, Portage, and Deborah at home.

◈ **David Charles Mountain, MD,** 65, Milwaukee, died Mar 20, 1977 in Milwaukee. Born June 25, 1911, in Pittsfield, Mass, Doctor Mountain graduated from George Washington University Medical School, Washington, DC in 1941. He served in the United States Navy during World War II. Surviving are his widow, Vivienne; two daughters, Mrs Paul (Jeanne) Kay, Salt Lake City, Utah, and Mrs Ronald (Nancy) Arian of West Milford, NJ; and one son, David of Poynette.

◈ **Porter B Blanchard, MD,** 71, Cedarburg physician, died Mar 22, 1977 in Cedarburg. Born May 16, 1905 in Linden, Wis, Doctor Blanchard graduated from the University of Wisconsin Medical School in 1932. He served on the State Medical Society's Committee on Cancer for many years and from 1961-1967 served as a councilor of the Society. Surviving are his widow, Jeanette; two sons, Robert, US Navy, and William of Indianapolis; and a daughter, Nancy of Chicago. ■

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The Laetrile Controversy

THE WISCONSIN LEGISLATURE is currently considering three bills (AB's 420, 317, and 476) which will make it possible to purchase the substance called laetrile, or amygdalin, without a prescription, over-the-counter, in drugstores and health food stores.

Laetrile (amygdalin) is a chemical which occurs naturally in the pits of apricots, peaches, bitter almonds, and other plant materials. Its promoters claim that it is Vitamin B_{17} and can prevent and cure cancer.

Although the *Merck Index* indicates that the words amygdalin and laetrile are interchangeable, their detailed chemical structures differ; therefore, it is not usually known what substance is supplied to cancer patients.

The Food and Drug, Cosmetic, and Toxic Substances Control Acts were passed by the US Congress to protect Americans. All drugs marketed in this country, whether for the treatment of cancer or the common cold, must undergo a rigorous series of scientific tests to determine their biologic and therapeutic activity as well as chemical purity and stability. Over 300,000 compounds have been tested in animals over the past two decades for their efficacy in treating cancer. Fewer than 50 have exhibited a significant degree of clinical therapeutic effectiveness; laetrile was not one of these.

Our national laws which are upheld by Wisconsin require that drug compositions be known and stated by the proprietor and seller on dispensing containers or in literature supplied with the drug. Nothing in these proposed bills requires that laetrile, or amygdalin, be of verified purity before being sold, so a patient would be completely at the mercy of those selling and dispensing the material. He would not really know what he was being treated with and would have little recourse if it were ineffective or caused untoward effects.

Reports on the toxicity of laetrile vary. Some indicate that it is very toxic, especially when taken orally. Others say that it is remarkably nontoxic, so that large doses can be taken for long periods without apparent ill effects. Toxic side effects increase when laetrile is used with beta-glucosidase, an enzyme which supposedly enhances its effectiveness.

Because of confusion about what is being given to cancer patients or sold as Bee-Seventeen or Aprikern in health food stores, a person desiring to obtain laetrile to treat cancer or as a health food supplement doesn't actually know what he is receiving. He has no assurance that it isn't an extremely toxic, crude extract of apricot pits or some unknown powder being sold for profit. Also no one knows if laetrile will be more toxic if a person is also taking aspirin, heart medicine, or anti-cancer drugs!

Laetrile supporters have never supplied the FDA with the information about toxicity and effects in animals required before human testing can be done. Animal studies which have been made with a variety of animal tumors haven't shown significant activity; therefore, well-controlled human studies have never been done. Most reports suggesting a positive effect of laetrile on human cancer have been anecdotal, and were not accompanied by medical proof of cancer, cancer stage, or clinical improvement; many of these patients also had been treated with surgery, radiation, or orthodox chemotherapy.

To circumvent FDA regulations, laetrile proponents have claimed it is Vitamin B_{17}. By definition, a vitamin is a chemical required in very small amounts for a person's health, well-being, and continued existence. Likewise, laetrile could not prevent cancer because it is not a universally available and consumed substance. There is absolutely no scientific evidence to support either of these claims.

Many protest that their right to freedom of choice is being interfered with because laetrile is not available as an anti-cancer drug. But freedom of choice can only be had with responsibility. Laws are passed in this country to protect our citizens, their health, welfare, and freedom from fraudulent claims by those who would misrepresent themselves and their products. *Freedom of choice without* RESPONSIBILITY voids our laws and voids our society as a viable one.

Of prime concern to all must be the good of the patient. We must be concerned with the exploitation of patients by non-ethical practitioners who operate outside the usual code of medical ethics or who promulgate materials for which they are going to make money without providing help. If laetrile is made freely available, many people who fear they have cancer may attempt to treat themselves and lose valuable time.

As a member of the medical profession, we urge you to contact your legislators. Encourage them to continue their efforts to improve the health and welfare of all Wisconsin citizens, especially those afflicted with cancer. But ask them not to legalize an unproven mode of therapy which plays on the fears of despairing patients and their families, yet compromises their responsible choice of proper and often life-saving treatment.

—DOROTHY J BUCHANAN-DAVIDSON, PHD,
Science Writer
Wisconsin Clinical Cancer Center

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

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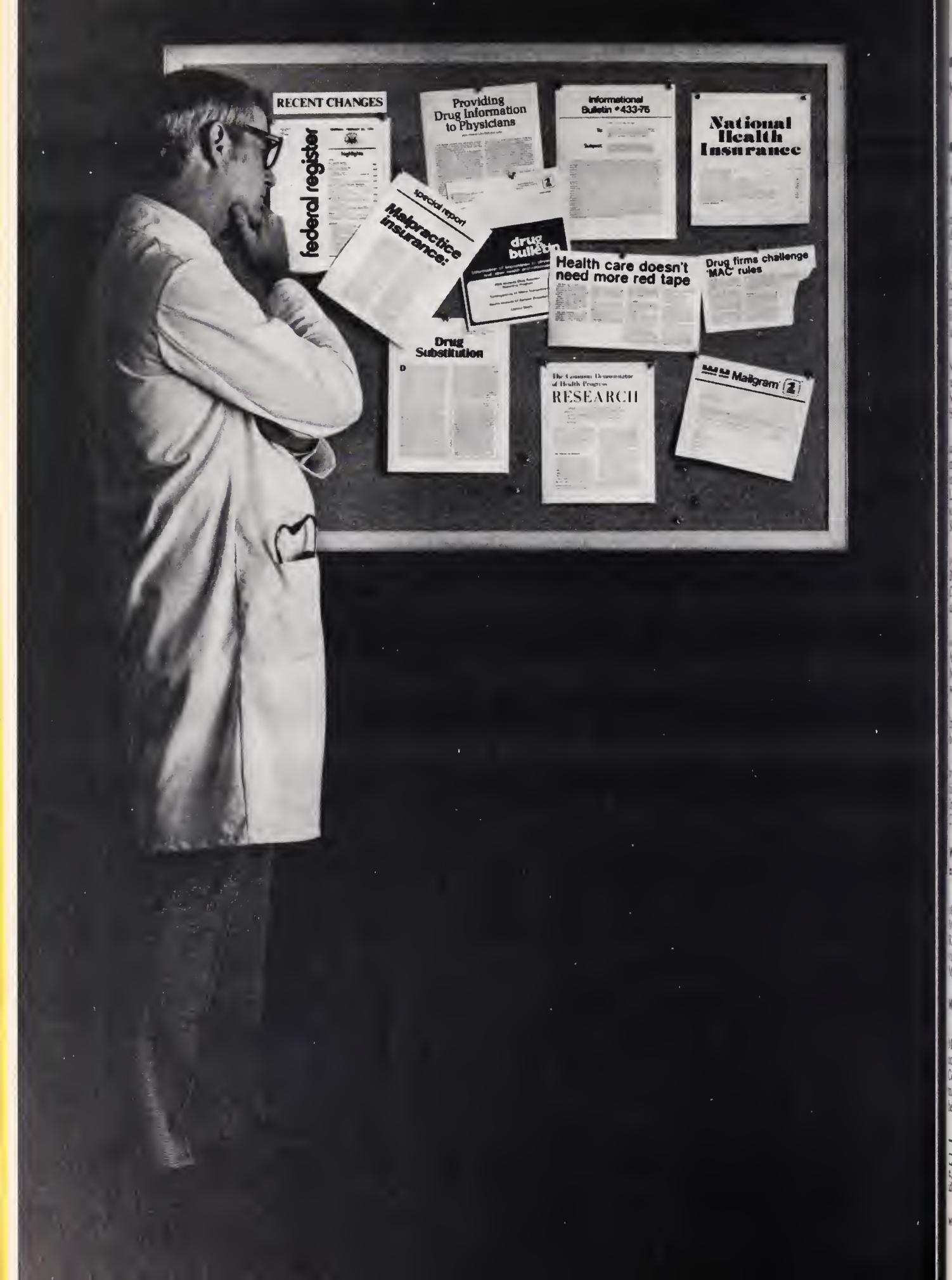
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special report
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drug bulletin
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Drug Substitution
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NEWS HIGHLIGHTS

Wisconsin Psychiatric

. . . Association will have its annual meeting Friday, June 3, at the Holiday Inn in Fond du Lac. Theme: *Psychopharmacology and Biofeedback.*

Darold A Treffert, MD*, Winnebago, program chairman, has promised an interesting and informative scientific program which includes the following:

The Joy of Treating Depression, by Nathan Kline, MD, New York, director, Rockland Research Institute, New York Department of Mental Hygiene.

Origins of Biofeedback and *Psychiatric Aspects of Headache,* by Seymour Diamond, MD, Chicago, director, Diamond Headache Clinic, Limited and clinical assistant professor of neurology, Chicago Medical School.

Demonstration/Clinic on the Use of Biofeedback, Various Modalities of Biofeedback, and Their Application to Clinical Practice, by Doctor Diamond and staff.

The Effect of the Lessard Decision on Adult Commitment Statistics, by A R Bedi, MB, BS, psychiatric fellow, Medical College of Wisconsin, Milwaukee.

A business meeting will be held from 4 to 5 pm followed by a social hour and a half.

The program is jointly sponsored by the Wisconsin Psychiatric Association and Winnebago Mental Health Institute, for which five hours of Category I credit will be allowed.

Wisconsin Society of Plastic and Reconstructive Surgeons

. . . has elected the following slate of officers effective April 16: Donald M Levy, MD,* Milwaukee, president; Ralph A Kloehn, MD,* Milwaukee, vice-president; and Jerome J Luy, MD,* Milwaukee, secretary-treasurer.

Marshfield Medical Foundation

. . . held its 17th annual meeting March 29 at the University of Wisconsin Center, Marshfield-Wood County. Community residents and medical professionals, totalling 325, heard Frederick Wenzel outline the new directions the Foundation must take in continuing its development. He said, "As the Foundation continues to grow, we have to re-examine our relationships and the coordination with Marshfield Clinic and St Joseph's Hospital. This is much more important than in the past when we were small."

Wenzel noted the Foundation staff has grown from 3 to 65 employes and its mission has expanded since its founding days in 1959. In an interview with a *Marshfield News-Herald* reporter, Wenzel said, "We will continue to put the major emphasis on research, both clinical and basic. But at the same time we must explore what depth of involvement to pursue in education and community service programs."

In his annual meeting speech Wenzel also noted 12 new physicians had been put under contract for 1977. The Foundation, which is a research-education-service arm of the medical complex in Marshfield, this next year will operate from a budget of between $2.8 and $3 million. This compares with a current budget of nearly $2 million, Wenzel stated.

Wenzel will be stepping down as executive director of the Foundation. He has been serving a dual role since being named executive director of Marshfield Clinic last September. The Foundation is attempting to find his replacement.

Newly named physicians to the 18-member Foundation Board of Directors are: MDs Edwin H Hoeper* and Raymond L Hansen* of the Marshfield Clinic. Special recognition was given the late Francis N Lohrenz, MD, who died last summer. Thomas F Nikolai, MD,* Foundation president, and Ben R Lawton, MD,* Marshfield Clinic president, also participated in the program, as did Robert H Greenlaw, MD* who is heading up efforts on Marshfield's cancer center planning grant.

Paul P Carbone, MD, was the guest speaker who gave an overview of cancer's causal and treatment steps. He is associate director of the Wisconsin Clinical Cancer Center; director of clinical oncology and director of medical oncology at University Hospitals, Madison.

PHYSICIAN BRIEFS

Michael P Mehr, MD*

. . . Marshfield, was reelected to a three-year term on the Board of Trustees of the American Society of Internal Medicine during its Annual Meeting, March 24-25, in Kansas City, Mo. A staff member of the Marshfield Clinic and St Joseph's Hospital in Marshfield, he also is assistant clinical professor of medicine at the University of Wisconsin Medical School. Doctor Mehr is chairman of ASIM's Patient Care Council and president-elect of the Wisconsin Society of Internal Medicine.

Jeremy E Alperin, MD

. . . Beloit, has joined the Beloit Clinic in the ear, nose and throat department. A graduate from the University of Vermont School of Medicine, his residency was completed at Case Western Reserve University Hospitals, Cleveland, Ohio. After finishing his training, Doctor Alperin remained at Case Western Reserve as assistant professor of ear, nose and throat and served as assistant director and chief of ear, nose and throat service at Cleveland Metropolitan General Hospital.

Bahij S Salibi, MD*

. . . neurosurgeon at the Marshfield Clinic since 1958, has been named counselor-at-large for the Executive Council of the Washington University Medical Center Alumni Association. A 1950 graduate of Harvard Medical School, Doctor Salibi will serve a one-year term from July 1977 through June 1978. He is the son of Dr and Mrs S K Salibi, Beirut, Lebanon, and is a third generation physician in the family.

Leighton Siegel, MD

. . . St Paul, Minn, recently became associated as a part-time consultant with the Hudson Clinic, SC in the specialty of the diseases of the ear, nose and throat. Doctor Siegel is a graduate of the University of Minnesota Medical School and is currently a clinical assistant professor at the University of Minnesota. A member of the American Academy of Ophthalmology and Otolaryngology, he practices in St Paul, Minn, but will devote one day a month to the Hudson Clinic.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Wisconsin Urological Society

. . . met March 25-26 in Milwaukee for its annual scientific meeting. During the business session, Kenneth A Forbes, MD,* Green Bay, was elected president and Raul F Waters, MD,* Madison, was elected secretary-treasurer. The next annual meeting of the WUS will be held during Spring 1978 in Madison.

Mercy Medical Center

. . . in Oshkosh has approved a long-range master plan for replacing and expanding its facilities to meet changing and future needs for health-care services. Bernard J Schlueter, president of Mercy, estimates the total cost of the project, including debt financing at $50 million.

The plan, presented by the firm of Berners, Schober and Kilp of Green Bay, is broken down into three phases, with the first phase totalling $8 million in construction costs, and about $12 million including all expenses. The first phase, expected to start in Summer 1978, will include an expansion wing to gain first priorities space needs for emergency/outpatient, radiology and rehabilitation and intensive care units. The other two phases involve long-range development with the second phase scheduled to begin 10 years from now, and phase three in 15 to 20 years.

Wisconsin Surgical Society

. . . elected officers at its April annual meeting as follows: P Richard Sholl, MD,* Janesville, president; Edward Bachhuber, MD,* Milwaukee, president-elect; Raymond Watson, MD,* Milwaukee, secretary-treasurer; and Gale Mendeloff, MD,* Milwaukee, recorder. New Council members are: George Kroncke, MD,* Madison, and Robert Isom, MD,* Oshkosh.

The Society also adopted the following:

STATEMENT ON ADVERTISING AND PUBLICITY OF THE WISCONSIN SURGICAL SOCIETY

It is the policy of the Wisconsin Surgical Society to oppose any erroneous or exaggerated information that may be used in the selection of a patient's surgeon. Members may be subject to disciplinary action if they attempt to obtain patients by advertising or publicity which:

(a) contains misrepresentation of facts;

(b) tends to mislead or deceive;

(c) contains a patient's laudatory statements about a physician;

(d) is intended or tends to create false or unjustified expectations of favorable results;

(e) implies that the physician has skills superior to other physicians of like training and experience engaged in his field or specialty of practice;

(f) related to fees other than his or her usual consultation fee or range of fees for specific types of procedures without fully disclosing variables and other relevant factors which might result in an increased fee;

(g) appeals to a lay person's fears or similar emotions;

(h) contains other representations or implications that tend to cause the average person to misunderstand or be deceived;

(i) is in the form of unsolicited medical reprints, even if from an accredited medical publication.*

*For a further explanation of this policy, see AMA, *Judicial Council Opinions and Reports.* Chicago, 1973, sec 27, p 29.

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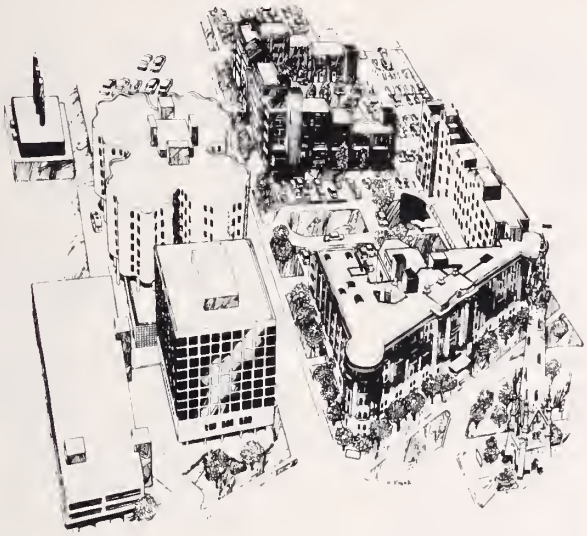

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Lloyd P Maasch, MD*

. . . Weyauwega, recently received the "Lion of the Year" award. Doctor Maasch a family practitioner, has had a perfect attendance record for his 20 years as a member. He also served as president in 1973-74 of the Lions Club and was on the Board of Directors.

Peter M Ihle, MD*

. . . orthopedic surgeon with the Ihle Orthopedic Clinic, Eau Claire, is now doing consultation work with the Barron-Chetek Medical Clinics, and has been appointed to the medical staff of the Barron Memorial Hospitals. Doctor Ihle is a graduate of the University of Wisconsin Medical School, Madison, and served his internship at St Luke's and Mercy hospitals in Cedar Rapids, Iowa. His residency training in surgery and orthopedics was taken at St Joseph's Hospital in Marshfield and University Hospitals, Madison.

Dave Ulery, MD

. . . Oconomowoc, recently became associated with the Wilkinson Clinic. A 1973 graduate of the Ohio State University Medical School, Doctor Ulery served his pediatric residency at the University of Wisconsin, Madison, from 1973-76. Prior to joining the Wilkinson Clinic, he had been in private practice in Springfield, Ohio.

Donald J Kuban, MD

. . . director of the blood derivative products division of Armour Pharmaceutical Company, has been named medical director of Arizona Blood Services. A native of Wisconsin, Doctor Kuban earned the MD degree and an MS degree in pathology from Marquette University School of Medicine. He served as director of St Luke's Hospital Blood Bank in Milwaukee, and as assistant professor of pathology at the Medical College of Wisconsin prior to joining Armour Pharmaceuticals in Phoenix in 1975.

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Lyle H Edelblute, MD*
Robert W Edland, MD*
Leslie E Jones, MD*

. . . recently were named Fellows of the American College of Radiology. Doctor Edelblute is affiliated with Bellin Memorial Hospital, St Mary's Medical Center and Brown County Mental Health Center, Green Bay; Oconto Memorial Hospital, Oconto, and Oconto Falls Community Memorial Hospital in Oconto Falls. Doctor Edland is affiliated with LaCrosse Lutheran and St Francis hospitals, LaCrosse. Doctor Jones is affiliated with St Agnes Hospital, Fond du Lac; Ripon Memorial Hospital, Ripon, and Berlin Memorial Hospital, Berlin.

Gene Numsen, MD

. . . pediatrician, recently joined the medical staff of the Rice Clinic, Stevens Point. Since 1971 he had been with the student health service at the University of Wisconsin-Stevens Point.

Joseph M Lubitz, MD*

. . . who currently serves as chairman of the SMS Commission on Governmental Affairs, recently was recognized by DePaul Rehabilitation Hospital for showing outstanding leadership in the alcoholism field and for his many years and hours of services to DePaul as a medical physician.

A resident of Oconomowoc, Doctor Lubitz served as the chairman of the Advisory Committee of Physicians and currently the Joint Conference Com-

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IOSEPH M LUBITZ, MD

nittee at DePaul. He was a member of the medical staff at DePaul from 962 to 1975, and served as a member of the Board of Directors since February 1972 to the present. Doctor Lubitz was instrumental in the growth of DePaul as a hospital and he chaired the Advisory Committee of Physicians in 1968 which resulted in the establishment of DePaul Rehabilitation Hospital as an accredited hospital.

Doctor Lubitz helped establish the medical staff at DePaul and through his efforts was able to see DePaul become the first specialty hospital to be approved in Wisconsin. Doctor Lubitz comments "As a hospital, DePaul has achieved national recognition in specialty alcoholism treatment in the medical area."

Doctor Lubitz is a clinical professor of pathology at the Medical College of Wisconsin and a member of the Advisory Group of the Wisconsin Regional Medical Program. His other professional affiliations are consultant to the Milwaukee County Medical Complex and the Veterans Administration Hospital, Wood.

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF APRIL 1977

5 Dane County Medical Society Board of Trustees
6 SMS Commission on Governmental Affairs
6 Ad Hoc Committee on Physical Therapy
7 SMS Committee on School Health
7 WHCRI-IMR Program
11 WisPRO-FMCE Long Term Care Committee
12 Title 19 Provider Agreement
13 *Finance Committe of SMS Council (Milwaukee)*
13 *Committee on Economic Medicine of SMS Council (Milwaukee)*
13 *Executive Committee of SMS Council (Milwaukee)*
13 *SMS Council (Milwaukee)*
14 *SMS Specialty Sections Delegates Caucus (Milwaukee)*
14 *SMS House of Delegates First Session (Milwaukee)*
14 *Milwaukee County Medical Society Auxiliary and Aesculapian Society Convention Reception (Milwaukee)*
14 *Open Hearings, AMA Delegates (Milwaukee)*
14 *House of Delegates Reference Committee Meetings (Milwaukee)*
14 *SMS Annual Meeting (Milwaukee)*
14 *SMS Auxiliary Annual Convention (Milwaukee)*
15 *SMS House of Delegates Second Session (Milwaukee)*
15 *SMS Annual Meeting (Milwaukee)*
15 *SMS Auxiliary Annual Convention (Milwaukee)*
15 *WISPAC Board Meeting (Milwaukee)*
16 *SMS Specialty Sections on Anesthesiology, Internal Medicine, Public Health and Preventive Medicine, Ophthalmology, Neurology, Pathology, Physical Medicine and Rehabilitation, and Surgery (Milwaukee)*
16 *SMS Annual Meeting (Milwaukee)*
16 *SMS House of Delegates Third Session (Milwaukee)*
16 *SMS Auxiliary Annual Convention (Milwaukee)*
16 *SMS Council (Milwaukee)*
20 SMS Committee on Occupational Health
20 SMS Committee on Federal Legislation
21 Citizens Advisory Council on Alcoholism and Other Drug Abuse
22 SMS Physicians Alliance Commission
22 SMS Medical Defense Committee
25 Dane County HMP Committee
26 Madison Society of OB-GYN
27 WHCRI-IMR Program
28 WHCRI Nominating Committee and Board of Directors
29 Subcommittee on Accreditation and SMS Commission on Continuing Medical Education

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parentheses.

New Diplomates, ABFP

. . . Fifty-one Wisconsin physicians recently became diplomates of the American Board of Family Practice by virtue of having passed the seventh certification examination. The following list has been released by the office of the ABFP:

Deogracias C. Almazar, Jr, MD,* Wittenberg
Richard L. Banning, MD,* Watertown
Michael Lee Beehner, MD,* Rice Lake
James R. Beix, MD,* River Falls
Mark P. Bishop, MD, Prairie du Sac
Clifford T. Bowe, MD,* Cadott
Mark Boyken, MD,* St Croix Falls
Keith E. Buchanan, MD,* Appleton
Mark Chalom, MD, Washburn
Robert S. Chudnow, MD, Hales Corners
Robert Lockey Cole, MD, Middleton
James L. Craig, MD,* New Richmond
Harold Paul Crissinger, MD,* Marinette
Richard Ellingstad, MD,* Burlington
Gene G. Enders, MD,* Menomonie
Marvin C. Faust, MD, Oshkosh
James D. Froehlich, MD, West Bend
Thomas Frederic Garland, MD,* Elm Grove
Michael C. Gordon, MD,* Janesville
Theodor Habel, MD, Eau Claire
John D. Hart, MD,* Shawano
Richard W. Hill, MD, Madison
Glenn Charles Hillery, MD,* Lancaster
David P. Imse, MD,* Delafield
Colin Douglas Jones, MD, Madison
Stuart D. Kaufman, MD,* Eau Claire
Robert C. Kaupie, MD,* Wausau
David P. Kelsey, MD, Frederic
A. A. Koeller, MD,* Ashland
Herbert F. Laufenburg, MD,* Cedarburg
Stephen A. Lindahl, MD,* Hudson
Henry Roger Mol, MD,* Elkhorn
Lan Albin Nelson, MD, Eau Claire
Gary K. Petersen, MD,* Black River Falls
David Leland Price, MD,* Appleton
William E. Raduege, MD,* Woodruff
Louis Richard Rosin, MD,* Superior
Douglas D. Salmon, MD,* Appleton
R. Malcolm Schmehl, MD, Durand
Norman Carl Schroeder, MD, Manitowoc
Teddy Leonard Thompson, MD, LaCrosse
Terry L. Turke, MD,* Watertown
Donald W. Vangor, MD,* Baraboo
Nicolas A. B. Venci, MD, Greenfield
Robert Sprague Viel, MD,* Brookfield
James Allen Walker, MD,* Menomonie
Marwood E. Wegner, MD,* St Croix Falls
Warren H. Williamson, MD,* Racine
Douglas Drew Wilson, MD,* Watertown
Darrell L. Witt, MD,* Wausau
William Ward Young, MD,* St Croix Falls

Ground Breaking Ceremonies

. . . for a new $14 million addition to the Veterans Administration Hospital in Madison was held in the hospital's auditorium May 6.

Late last year the President signed legislation designating the Madison VA hospital as the William S Middleton Memorial Veterans Hospital.

The new wing addition will connect the VA hospital with the new University of Wisconsin Medical Center for Health Sciences now under construction adjacent to the VA hospital.

Max Cleland, the newly appointed head of the Veterans Administration gave the main address.

Lawrence Hanley, MD*

. . . director of the Eau Claire Family Practice Residency Program, which began two years ago, has announced the addition of four physicians to the program beginning July 1. These additions will bring the program up to its original quota of 12 physicians going through residency. Doctor Hanley reported 10 physicians are now in training, and two will graduate June 30. Approximately 90 physicians applied for the residency program, and 70 were interviewed before the 4 were selected, Doctor Hanley said.

Residents who will begin training in Eau Claire in June are Bruce A Bonde, MD, Falcom Heights, Minn, a graduate of the University of Minnesota Medical School; Thomas P Harvey, MD, Short Hills, NJ, a graduate of Baylor Medical School; Rodney G Olson, MD, Brainerd, Minn, a graduate of the University of Minnesota Medical School; and Joseph J Sandor, MD, Hobart, Ind, a graduate of the University of Arizona Medical School.

Dale Peterson, MD, a native of Mora, Minn, has been added to the staff as the second full-time faculty member. He is a graduate of the University of Minnesota Medical School.

Doctor Hanley reported 80 percent of graduates from the University of Wisconsin residency program stay in the state, and 86 percent of those remain in the community where they were trained. "This is about twice the national average for family practice training programs," he commented.

Mohammed Ghafoor, MD

. . . Merrill recently became associated with MDs Lester Bayer* and Yusof Ahmad* of Merrill Medical Associates. Doctor Ghafoor graduated from King Edward Medical College in Lahore, Pakistan and served his internship at McNeil Memorial Hospital, Berwyn, Ill. His residency in Internal Medicine was taken at the University of Illinois Hospital in Chicago. Doctor Ghafoor served a fellowship in infectious diseases at the hospital for two years and later accepted a teaching position until moving to Merrill.

Thomas R Youngren, MD

. . . currently participating in a three-year family practice residency at Bethesda Hospital in St Paul, Minn, will be joining the medical staff of the Cumberland Medical Clinic on July 1.

Marc J Musser, MD

. . . chief medical director of the Veterans Administration from 1970 to 1974, died at the Washington VA Hospital March 29 after a long illness. He was 66 years old. Since retirement from the VA in 1974, Doctor Musser had served as a consultant to Smith, Kline & French Laboratories, with offices in Washington. Doctor Musser had a distinguished career in medical administration and medical education which started in Wisconsin. He received a BA degree in 1930 and an MD degree in 1934 from the University of Wisconsin. He completed residencies in neuropsychiatry and internal medicine at the Wisconsin General Hospital in Madison. He joined the University of Wisconsin Medical School faculty in 1938, attaining the rank of Professor of Medicine in 1953. Doctor Musser is survived by his widow, the former Alice Balcuns Dryden of the family home, 4538 North 39th Street, Arlington, Va, three sons, David Musser of Madison, Steven Musser of Minneapolis, and William S Musser of Arlington; and a daughter, Mrs Barbara Billek of Madison. The family had suggested that contributions be made in memory of Doctor Musser to Arlington Hospital Association, Inc, Arilngton, Va; Children's Hospital, Washington, DC; or other charities.

Richard F Harvey, MD

. . . Madison, is the new clinical director and acting chairman of the Department of Rehabilitation Medicine at University Hospitals, Madison. Doctor Harvey replaces Donald T. Fullerton, MD* who had been acting chairman of the department. Doctor Harvey is a graduate of the University of Illinois College of Medicine; he served his residency at the Mayo Clinic, Rochester. He had been vice-president for medical affairs and director of Rehabilitation Medicine at Rockford Memorial Hospital before coming to Madison.

Robert Chudnow, MD

. . . has joined James Clemence, MD* and Robert Jachowicz, MD* at the Hales Corners clinic. Doctor Chudnow received his medical degree from the University of Wisconsin-Madison in 1972. He served his internship at Santa Clara Valley medical center and his residency at St Luke's Hospital.

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Bascom Professorship

. . . at the University of Wisconsin-Madison has been recommended for Robert L Metzenberg Jr, professor of physiological chemistry, by the UW System Board of Regents.

Established in 1965, the John Bascom Professorships are named for the University's fifth president. They reward excellence in the teaching of undergraduates with a $5,000 annual stipend used to support the recipient's teaching and research.

Metzenberg's teaching in the Medical School, Center for Health Sciences, involves graduate and undergraduate courses in cell biology and physiological chemistry for medical students.

He has done research in genetics and most recently has been exploring how cells control the manufacture of various proteins.

With Metzenberg's appointment, UW-Madison now has 14 Bascom Professors.

Health Care Management

. . . Regents of the University of Wisconsin System in February accepted a $972,502 grant from the W K Kellogg Foundation of Battle Creek, Mich for establishment of a Center for Advanced Study in Health Care Fiscal Management, Organization, and Control at UW-Madison.

The Center will be a part of the Graduate School of Business and will offer educational programs at the doctoral, master's, and undergraduate levels.

The new center, the first of its kind in the United States, will concentrate on training professionals in all aspects of health care fiscal management, including attention to cost containment and control in the health care industry.

Other areas of activity will be advanced continuing education programs and a repository for health care fiscal management information. ■

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Schedule of Upcoming Programs

May 30 through June 12

The Diagnosis of Hyperthyroidism: A Decade of Progress. This telecourse is cosponsored for continuing medical education credit by downstate Medical Center, State University of New York, and qualifies for one hour of Category 1 credit for the AMA-PRA. It also is accepted for one hour of prescribed credit by the AAFP. AOA members may earn credit in Category 2. Program features Sidney H Ingbar, MD, Professor of Medicine and Director of the Thorndike Laboratory, Harvard Medical School and Beth Israel Hospital, Boston.

Primary Biliary Cirrhosis: Management of an Enigma, with Fenton Shaffner, MD, George Baehr Professor Medicine and Chief, Division of Liver Disease, Mt Sinai School of Medicine, New York.

June 13 through July 10

Evaluating Patients with Occlusive Cerebral Vascular Disease, with Noble J David, MD, Chief of the Neurology Service, Miami Veterans Administration Hospital, and Professor of Neurology at the University of Miami, Florida.

Papilledema Vs Pseudopapilledema: Recognition and Diagnostic Considerations, with Richard E Goldberg, MD, Director and Larry E Magargal, MD, Co-director, Retinal Vascular Unit, Wills Eye Hospital, Philadelphia, and the Retina Unit of Holy Redeemer Hospital, Meadowbrook, Pennsylvania.

The Beta Adrenergic Theory of Atopic Disorders, with E William Rosenberg, MD, Professor of Dermatology and Associate Dean, University of Tennessee College of Medicine, Memphis; and Andor Szentivanyi, Professor of Pharmacology and Internal Medicine, and Chairman of the Department of Pharmacology, University of South Florida College of Medicine, Tampa.

July 11 through August 7

Drugs and the Menopause Workshop, with John Moyer, MD, Director of Professional and Educational Affairs, Conemaugh Valley Memorial Hospital, Johnstown, Pennsylvania; Elizabeth Connell, MD, Associate Director of Health Sciences, Rockefeller Foundation, New York City, and consultant to Obstetrics and Gynecology Advisory Committee of FDA; Herbert Kupperman, MD, PhD, Director of Endocrinology, Lenox Hill Hospital and Associate Professor of Medicine, New York University Medical Center, New York City; Theodore King, MD, PhD, Chairman of the Department of Obstetrics and Gynecology, Johns Hopkins Medical School, Baltimore, MD, and Chairman of the FDA Obstetrics and Gynecology Advisory Committee.

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in most videotape and videocassette formats.

DOCTORS—The message appearing on the opposite page, "What's there to do besides DRUGS?," could be removed from the Journal for placement in your reception area. Also, a poster-size colored copy of this illustration and a booklet describing the alternatives to drugs are available upon request to the Wisconsin Clearinghouse for Substance Abuse and Information, PO Box 841, Madison, Wis 53701.

WPS

report

for Wisconsin Physicians

Volumn VI, Number 3

May 1977

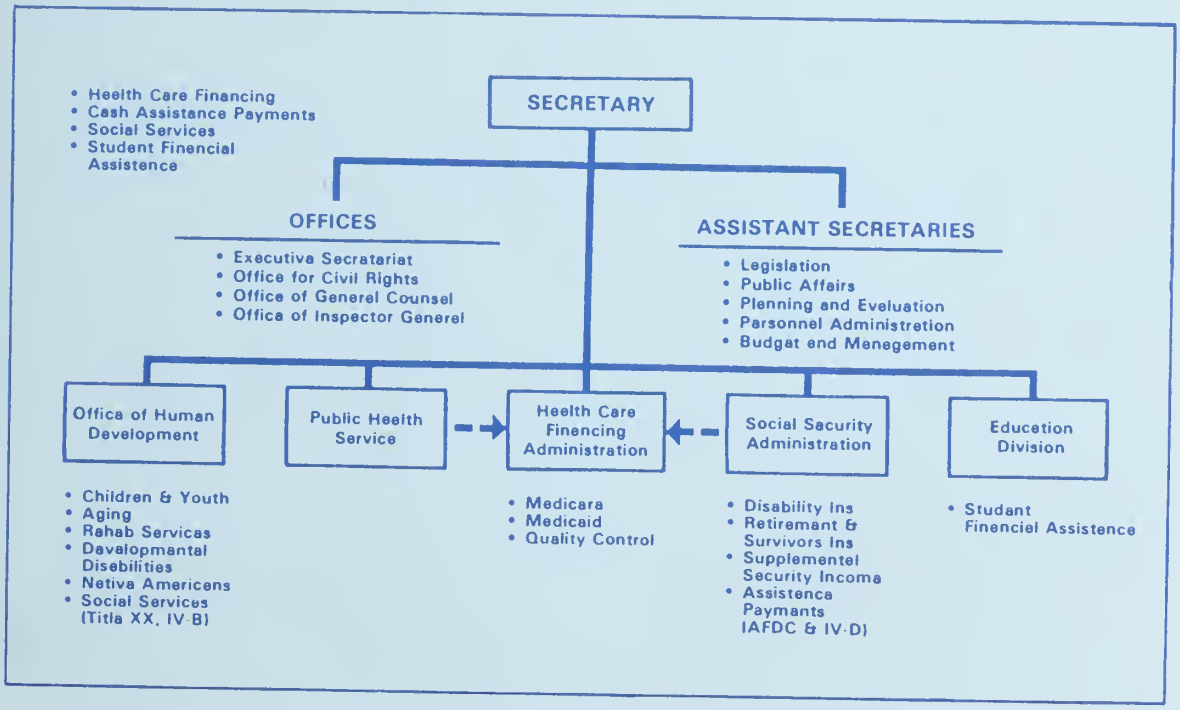
PROPOSED HEW REORGANIZATION

Because of the medical community's interest in the workings of the Department of Health, Education and Welfare and WPS's involvement in government health programs (Medicare Part B), WPS has monitored the transition in the Department of Health, Education and Welfare during the change in Administrations.

Soon after his confirmation, HEW Secretary Joseph A. Califano, Jr. announced a series of organizational steps which, in his opinion, would improve the operational workings of HEW, would make delivery of service more efficient and increase its efforts in controlling fraud and abuse.

Of the five principal reorganization actions, the one most pertinent to the health care environment establishes the Health Care Financing Administration. This action places the oversight of Medicare and Medicaid, and related quality assurance programs, under one administrator. The person expected to hold that position is Robert Derzon, director of hospitals and clinics for the University of California at San Francisco. HCFA will have a staff of 3800; approximately 900 will be involved in quality control activities.

The following is a chart of the reorganized Department of Health, Education and Welfare that Secretary Califano is proposing.



Report is a service to the physicians of Wisconsin.

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SOME ACRONYMS DECIPHERED

During the last 25 years, American medicine has witnessed the growth of a confusing array of committees, commissions, certifying bodies, bureaus, departments, and other health care organizations. Because the names of these organizations are long and technical, acronyms are used to speed communications about them in conversation and to save space in forms and publications. Now that there are so many of these organizations, decoding the acronyms has become a problem. The following is a list of selected acronyms you can refer to when you find yourself stumped by an acronym.

BHI ..... Bureau of Health Insurance of the Department of Health, Education and Welfare

BQA..... Bureau of Quality Assurance of the Department of Health, Education and Welfare

CHAP.... Certified Hospital Admission Program

CHP..... Community Health Programs

CQA .... Concurrent Quality Assurance

CRT..... Cathod-Ray-Tube

CSR ..... Continued Stay Review

DUR .... Drug Utilization Review

ECF ..... Extended Care Facility

EMS..... Emergency Medical Services

FDA..... Food and Drug Administration

FEP ..... Federal Employees Program

FI ..... Fiscal Intermediary

FMC..... Foundation for Medical Care

HCF..... Health Care Foundation

H-ICDA .. Hospital Adaptation of International Classification of Diseases

HMO .... Health Maintenance Organization

HRA .... Health Resources Administration of the Department of Health, Education and Welfare

HSA..... Health Services Administration of the Department of Health, Education and Welfare; Health Service Areas; Health Systems Agencies

ICDA .... International Classification of Diseases, Adapted

LOS ..... Length of Stay

LTCF .... Long Term Care Facility

MCE..... Medical Care Evaluation (Study)

MIS ..... Medical Information System

MMIS.... Medicaid Management Information System

NHI ..... National Health Insurance

OTC..... Over-the-Counter (Drugs)

PAC ..... Pre-Admission Certification

PAS ..... Professional Activity Study

PAT ..... Pre-Admission Testing

PHP ..... Prepaid Health Plans

POMR.... Problem-Oriented Medical Records

PSRO.... Professional Standards Review Organization

QAP..... Quality Assurance Program

SSA ..... Social Security Administration

UR..... Utilization Review

WHCRI... Wisconsin Health Care Review, Inc.

WisPRO .. Wisconsin Professional Review Organization

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OB-GYN, PEDIATRICS SPECIALists needed by 16-man multispecialty clinic in university community of 50,000 in Western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R Ujda, MD, LaCrosse Clinic, 212 South 11th St, LaCrosse, Wis 54601. 9-12/76,1-8/77

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PRIMARY CARE PHYSICIAN'S ASsistant, board eligible, seeking physician general or group practice. Contact Gary Umland, PA, 9131 West Cleveland Ave, West Allis, WI 53214. 5/77

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OFFICE SPACE FOR RENT: Courtland Medical Center Building. Excellent location - 68th at West Capitol Drive, Milwaukee, Wis. Full lab and x-ray facilities available. Call 414/463-3704. 3/77*

USED EQUIPMENT WANTED TO buy by family physician starting new office. Furniture, office business, exam, and lab equipment needed. Reply in writing to S J Carlson, MD, 123 Bayview, Shell Lake, WI 54871. 5-6/77

FOR LEASE: OFFICE SPACE IN professional building two blocks east of West Allis Hospital. Entire ground level. 2400 sq ft. Parking lot. Will divide or remodel. Upper level occupied by two pediatricians. Available now. Contact Lincoln Properties, Inc, 8511 West Lincoln Ave, West Allis, Wis 53227; phone 414/543-8860. 5-7/77

FOR LEASE: WISCONSIN — MODern medical clinic for lease, equipped, in lovely area, large black top parking lot, 2 hospitals within 10 miles, unopposed practice, ideal for general practitioner, tremendous potential. Terms open. Principals only please. Contact Dept 450 in care of the Journal. p5/77

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OFFICE SPACE AVAILABLE: 1100 sq ft, Lincoln Center Professional Building, West Allis. Tel: 414/321-2720. 5-6/77

WISCONSIN MEDICAL JOURNAL, September 1943 issue, needed for binding, or complete set or volume for year 1943. Willing to pay. *Wisconsin Medical Journal*, Box 1109, Madison, Wis 53701; tel: 608/257-6781, ext 125. 4tfn/77

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Prevention of Heart Attack: A Challenge to the Health Professions. By George A Hellmuth and Phillip J Hellmuth. University Microfilms International, 300 North Zeeb Rd, Ann Arbor, MI 48106. 1977. Pp 343. Price: $21.75.

Breast-feeding and the Mother. Ciba Foundation Symposium 45. CIBA Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1976. Pp 280.

Medical Risks. By Richard B Singer and Louis Levinson. D C Heath and Co, Lexington Books, 125 Spring St, Lexington, MA 02173. 1976. Pp 736. Price: $27.50.

Catalogue of the Post-Graduate Course on Abdominal Surgery. Published in Master and Doctorate level. Imprensa Universitaria, Caixa Postal 1.621—30.000 Belo Horizonte—Minas Gerais—Brasil. Pp 44.

The Wholistic Health Centers: A New Direction in Health Care. By Robert M Cunningham, Jr. The W K Kellogg Foundation, 400 North Ave, Battle Creek, MI 49016. 1977. Pp 55.

Immunologic Psychology and Psychiatry. By Wallace Marshall, MD. University of Alabama Press, Drawer 2877, University, AL 35486. 1977. Pp 182. Price: $15.00.

Pharmacists: Descriptive Statistics 1976. Division of Health, Wis Dept of Health & Social Services, PO Box 309, Madison WI 53701. Pp 31.

The Diabetic's Sports and Exercise Book. J B Lippincott Co, Philadelphia, PA 19105. 1977.

The Medical Malpractice Dilemma. American Enterprise Institute for Public Policy Research, 1150 17th St, NW, Washington, DC 20036. Pp 46. Price: $2.00.

WIAA Yearbook Reviewing 1975-76. 53rd Annual WIAA Yearbook. John E Roberts, Exec Dir, 41 Park Ridge Dr, Stevens Point, WI 54481. Pp 244. ■

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CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 9, 1976.

1977 WISCONSIN

Jun 3: Wisconsin Psychiatric Association annual meeting, Holiday Inn, Fond du Lac. See further details in NEWS HIGHLIGHTS section of this issue.

Jun 3: Annual Scientific Sessions of American Heart Association/Wisconsin Affiliate, at Performing Arts Center, Milwaukee. *Pre and Post Hospital Aspects of Myocardial Infarction.* Info: Ms Pat Erdmann, AHA/Wisconsin Affiliate, 795 North Van Buren, Milwaukee, Wis 53202. Tel: 414/271-9999.

Jun 25: Leukemia Society of America Medical Symposium, sponsored with the Medical College of Wisconsin, Milwaukee. See details in box elsewhere in this issue.

Jun 26-30: *Sixth Annual Mid-America Hospital Medical Staff Conference,* at the Abbey in Fontana. Cosponsored by the Medical Society of Milwaukee County and the Hospital Council of Greater Milwaukee in conjunction with the Estes Park Institute. Approved for 32 hours of credit in continuing education (Category I) by the AMA. Tuition: $190. Info: Estes Park Institute, PO Box 400, Englewood, Colo 80151; phone 303/761-7709.

Jul 15-16: Dr A Jampolski, sponsored by Dept of Ophthalmology, University Hospitals, Madison.

Jul 17-22: Eleventh Annual Summer Institute: *Strengthening Community Programming in the Field of Alcohol Abuse and Alcoholism,* University of Wisconsin Campus, Madison. Info: Richard F Buckley, Associate Professor, Center for Social Service, UW-Extension, 322 Lowell Hall, 610 Langdon St, Madison, Wis 53706.

Sep 10-11: *Academic Anesthesia: Fifty Years After* Conference, University of Wisconsin, Madison. Objectives: The appointment of Ralph M Waters, MD to the faculty of the University of Wisconsin in 1927 marked the beginning of a new era in anesthesiology. All sessions at Wisconsin Center. Conference fee: $27 for members of Wisconsin Society of Anesthesiology, $62 nonmembers. Info: CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

Sep 16-17: Dr Robert Shaffer, sponsored by Dept of Ophthalmology, University Hospitals, Madison.

Oct 7-9: Wisconsin Radiological Society, Concourse Hotel, Madison.

CONFERENCES FOR MEDICAL PROFESSIONALS.

Over 500 listings of national/international meetings, conferences and seminars in the medical sciences for 1977. Send a $10.00 check or money order payable to Professional Calendars, PO Box 40083, Washington, DC 20016. p1-6/77

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1977 NEIGHBORING

Jun 13-15: *Vascular Surgery* course designed primarily for surgeons. Sponsored by Dept of Surgery, University of Minnesota, at West Bank Auditorium, U of Minn, Minneapolis. Credit: 22 hours. Fee: $200. Accredited for AMA-PRA. Info: Office of Continuing Medical Education, U of Minn Medical School, Box 293 Mayo Memorial Bldg, Minneapolis, Minn 55455; phone 612/373-8012. g5/77

Jun 13-18: *Management of Cerebral Palsy,* sponsored by Dept of Physical Medicine and Rehabilitation, University of Minnesota, at Children's Rehabilitation Center, U of Minn campus, Minneapolis. Credit: 42 estimated. Fee: $185. Info: Office of CME, U of Minn Medical School, Box 293 Mayo Memorial Bldg, Minneapolis, Minn 55455; phone 612/373-8012. g5/77

Jun 15-17: Three-day international symposium on *Fermented Food Beverages in Nutrition,* cosponsored by Mayo Clinic-Mayo Foundation and The Nutrition Foundation, at Rochester, Minn. Will explore the dietary role of fermented food beverages, such as beer and wine. More than 50 scientists from the United States and other countries will present papers. Info: Dr Clifford Gastineau, Dept of Endocrinology, Nutrition and Internal Medicine, Mayo Clinic, Rochester, Minn 55901. g4-5/77

Jun 16-17: *National Pediatric Conference,* sponsored by Dept of Pediatrics, U of Minnesota, and U of Minnesota Duluth, at Mayo Memorial Auditorium, U of Minnesota, Minneapolis. Accredited for AMA-PRA. Info: Office of CME, U of Minn Medical School, Box 293 Mayo Memorial Bldg, Minneapolis, Minn 55455; phone 612/373-8012. g5/77

1977 Annual Symposium on Acute Leukemia

The State of the Art—A Dialogue Between Clinicians and Research Workers

Saturday, June 25—Milwaukee

PFISTER HOTEL—9 am to 4 pm
Registration starts at 8 am

Sponsored by the Medical College of Wisconsin in association with the Leukemia Society of America

Faculty consists of the following distinguished scientists:

Prof Dirk W vanBekkum, Director of Radiobiological Institute, Rijswijk, The Netherlands. He is former president of EROTC—European Research Organization for Treatment of Cancer—and Professor of Medicine at Leiden University and at Rotterdam University.

Dr Leon Shwartzenburg, Associate Director, Institut d Cancerologie et de' Immunogenetique, Villejuif, France. He is an outstanding authority on immunotherapy of acute leukemia.

Frank M Schabel Jr, PhD, Associate Director, Southern Research Institute, Birmingham, Ala.

John Kersey, MD, Associate Professor, Department of Pathology, University of Minnesota School of Medicine.

James Cox, MD, Associate Professor of Radiology, Medical College of Wisconsin; and Director, Division of Radiation Therapy, Milwaukee County Medical Complex, Milwaukee.

John H Holcenberg, MD, Professor of Pediatrics and Professor of Pharmacology, Medical College of Wisconsin, Milwaukee.

John D Hurley, MD, Clinical Associate Professor of Surgery, Medical College of Wisconsin; and Medical Director, Masonic Diagnostic and Treatment Center, Deaconess Hospital, Milwaukee.

Mark Nesbitt, MD, Professor of Pediatrics, University of Minnesota School of Medicine, Minneapolis.

Donald Pinkel, MD, Professor and Chairman, Department of Pediatrics, Medical College of Wisconsin; and Medical Director, Midwest Childhood Cancer Center, Milwaukee.

Robert Truitt, PhD, Special Fellow, Leukemia Society of America, Inc and Research Associate at Winters Research Laboratory, Mt Sinai Medical Center, Milwaukee.

Credit: *Fully accredited by AMA for Category I* (6 credits).

Preregistration fee: $15; late fee $20.

Further info: Leukemia Society of America, Inc, Wisconsin Chapter, 411 East Mason St, Milwaukee, Wis 53202.

Phone: 414/271-4880

University of Wisconsin-Madison Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

CME Calendar—1977

June 15: *Maternal and Infant Care: Intrapartum Problems II,* Beaver Dam Community Hospitals, Beaver Dam.

June 22-25: *The Society of Psychotherapy Research,* The Wisconsin Center, Madison.

Aug 10-12: *The Second International Meeting on Tryptophan Metabolism: Biochemistry, Pathology and Regulation,* Dr Ray Brown, Chairman, The Wisconsin Center, Madison. Fee: $70.

Aug 16-19: *Educational Resources,* The University Bay Center, Madison.

Aug 29-Sep 2: *Emergency Care Conference,* The Wisconsin Center, Madison.

Sep 10-11: *50th Anniversary Anesthesiology Program,* The Wisconsin Center, Madison. Fee: Members $27; Nonmembers $62.

Sep 15-18: *Family Practice Review Boards,* The Edgewater Hotel, Madison.

Sep 16-17: *Plastic Surgery for the Primary Care Physician,* The University Bay Center, Madison.

Sep 21: *Maternal and Infant Care: Infant Assessment and Early Management,* Beaver Dam Community Hospitals, Beaver Dam.

Sep 30-Oct 1: *Hospital Administration,* The University Bay Center, Madison.

Sep 30-Oct 1: *A Conference on Dermatology,* The Wisconsin Center, Madison.

Sep 30-Oct 1: *Trauma Symposium,* St Marys Hospital Medical Center, Madison.

Oct 19: *Maternal and Infant Care: Special Neonatal Problems I,* Beaver Dam Community Hospitals, Beaver Dam.

Oct 26-28: *50th Anniversary Preceptorship Program,* The Wisconsin Center, Madison

Nov 10-12: *Interventional Radiology,* The Wisconsin Center, Madison.

Nov 16: *Maternal and Infant Care: Special Neonatal Probblems II,* Beaver Dam Community Hospitals, Beaver Dam.

Nov 17-19: *A Conference on Epilepsy,* The Wisconsin Center, Madison.

Info: Coordinator, Dept of CME, 601 Walnut Street, Madison, Wis 53706; phone: 608/263-2850.

American Medical Association

HOSPITAL MEDICAL STAFF LEADERSHIP WORKSHOPS

for Continuing Medical Education Category I Credit

Locations and Dates

Atlanta, Ga, Marriott Motor Inn (Downtown), June 10-11

Columbus, Oh, Carrousel Inn, Sept 16-17

Philadelphia, Pa, Marriott Motor Inn (Downtown), Sept 23-24

Chicago, Il, Marriott Motor Inn (O'Hare), Oct 7-8

Dallas, Tx, Marriott Motor Inn (Downtown), Nov 4-5

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1977 Meeting Dates/Sites

National Medical Specialty Societies

June 20-23: Society of Nuclear Medicine, Chicago, Ill, Annual.
July 14-16: American Academy of Orthopaedic Surgeons, Denver, Colo, Interim (Summer Institute).
Sep 28-30: American Society of Internal Medicine, District of Columbia, Interim.
Oct 1: American Council of Otolaryngology, Dallas, Tex, Annual.
Oct 2-6: American Academy of Ophthalmology and Otolaryngology, Dallas, Tex, Annual.
Oct 2-6: (Tentative date) American Council of Otolaryngology, Dallas, Tex, Annual.
Oct 10-13: American Academy of Family Physicians, Las Vegas, Nev, Annual.
Oct 15-19: American Society of Anesthesiologists, New Orleans, La, Annual.
Oct 17-21: American College of Surgeons, Dallas, Tex, Annual.
Oct 21-28: American Society of Clinical Pathologists, Las Vegas, Nev, Annual.
Oct 21-28: College of American Pathologists, Las Vegas, Nev, Annual.
Oct 23-29: American College of Gastroenterology, New Orleans, La, Annual.
Oct 30-31: American College of Preventive Medicine, Atlanta, Ga, Annual.

American Cancer Society Kentucky Division

Conference on Cancer of the Bladder and Prostate

Friday-Saturday, Nov 4-5
Stouffer's Inn, Louisville, Ky

Space limited
No registration fee

Further info: George A Sehlinger, MD, President, American Cancer Society, Kentucky Division, 2313 Medical Arts Building, Louisville, Ky 40217

Meetings of the American College of Surgeons

CLINICAL CONGRESSES
1977: Oct 17-21—Dallas
1978: Oct 16-20—San Francisco
1979: Oct 22-26—Chicago
1980: Oct 20-24—Atlanta

SPRING MEETINGS
1978: Mar 13-16—Cincinnati
1979: Apr 2-5—Denver
1980: Mar 24-27—Toronto

Info:
American College of Surgeons
55 Erie St East, Chicago, Ill 60611

1977 OTHERS

Nov 4-5: *Conference on Cancer of the Bladder and Prostate,* American Cancer Society-Kentucky Division, at Stouffer's Inn, Louisville, Ky. Info: George A Sehlinger, MD, President, ACS-Kentucky Div, 2313 Medical Arts Bldg, Louisville, Ky 40217.
g5-10/77

1977 AMA

Jun 18-22: AMA Annual Meeting, San Francisco, Calif, Fairmont Hotel and Tower; San Francisco Convention Center—Brooks Hall.
Aug 8-13: "Medinfo '77"—2nd International Conference on Medical Computing, cosponsored by the Canadian Medical Association, International Federation for Information Processing; and World Health Association.
Nov 10-11: AMA 16th National Conference on Physicians and Schools, Regency Chicago, Chicago.
Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.
Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.
Dec 20-23: AMA National Leadership Conference.
Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

CONTRIBUTIONS—CES FOUNDATION March 1977

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for March 1977.

Unrestricted

Anonymous; Brian C McLaughlin, MD; Margaret C Winston, MD; Dane County Medical Auxiliary; Eau Claire-Dunn-Pepin County Medical Auxiliary; Outagamie County Medical Auxiliary; Sheboygan County Medical Auxiliary; Trempealeau-Jackson-Buffalo County Medical Auxiliary; Milwaukee County Medical Auxiliary; Racine County Medical Auxiliary; and Kenosha County Medical Auxiliary—*Voluntary contributions*

Restricted

American Family Insurance Co—*Medical Student Summer Externship Program*
Membership Dues—*Aesculapian Society*

Memorials

Dr-Mrs RT Schmidt—*Francis Lindemann; Vincent Shippy, MD (Brown County Loan Fund)*
Dr-Mrs RW Edwards—*Mr Ed Pohorney*
State Medical Society—*Donald E Gill; Paul E Millington, MD; Robert D DeCock, MD; Thomas F McCormick, MD; Thorn Vogel, MD*
EJ Nordby, MD; Marion P Crownhart; State Medical Society—*Raymond Rueckert, MD*
Wisconsin Physicians Service—*James Fitzgibbon; Vernon Sturtz; Vanita Ninneman; Steven Norman; Hazel Bennett; David J Bingham*
Marjory May; Friends at WPS—*Hazel Bennett*
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Barbara and Howard Brower—*Donald E Gill; H Russell Brown, MD*
Dr-Mrs Wm Grover—*John Kline*
Dr-Mrs NA Hill; Dr-Mrs CJ Picard; Marion P Crownhart—*Donald E Gill* ■

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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The foregoing principles may be changed at any time without notice.

"Bureau" as used above refers to the State Medical Journal Advertising Bureau, Inc., Oak Park, Illinois.

DO NOT USE "HONOR ALL CONSULTS"

The Nursing Home Ombudsman Office has informed the SMS that it has observed the notation, "honor all consults," on the charts of certain patients in some nursing homes. Those three words . . . "honor all consults" . . . could cause some big problems for physicians who enter them on a chart. The SMS Commission on Peer Review has stated that orders should be in writing and that each modality of recommended treatment should be on specific order of the attending physician. In this regard, a specific order for a specific modality keeps the attending physician in control of a patient's plan of care. The Commission recommends that no physician write "honor all consults" under any circumstances.

STATEMENT ON THERMOGRAPHY

The House of Delegates of the State Medical Society, at its April Annual Meeting, adopted the following statement on thermography:

In the detection of cancer of the breast, the State Medical Society of Wisconsin warns the public against thermography when used as a sole diagnostic or screening tool. It is felt, in light of the current nondiscriminate level of positives, as well as the high incidence of false negatives, thermography potentially can give the patient a false sense of security leading to delays in seeking evaluations which could avoid the unfortunate consequences of late diagnosis.

"The most effective type of breast cancer detection available at the present time is regular monthly breast self-examination combined with periodic health examination by a physician. Mammography and xerography should be used as indicated in the individual case.

Patients are strongly encouraged to work closely with their personal physicians in all health-care problems, including physical examinations, on a regular basis.

PAYMENT SYSTEM FOR ACTIVE DUTY ARMY PATIENTS

The US Army Medical Department Activity Unit in Fort Sheridan, Illinois has informed the State Medical Society that "a number of active duty Army members who have used civilian medical care facilities within your state have received various complaints and even threats of collection agency action from civilian providers as a result of delay in payments of their medical bills." The processing of all civilian medical claims generated by active duty Army members is the responsibility of the Commander, USA MEDDAC, Attention: Medical Claims Section, Fort Sheridan, Illinois 60037. The active duty Army member submits, or has submitted for him, his bills to the address listed above. Currently, it is taking the military offices about 90 days from the date the claim is received until a check is issued to the provider. The Army suggests that providers caring for an active Army member patient should do the following:

(1) Insure that the patient's name, rank, social security number, complete military organization address, and diagnosis is included on the invoice or statement of charges.
(2) Place the following statement on the invoice or statement of charges: "Certified just and correct. Payment not received. Charges as stated are reasonable for this area."
(3) Prepare and forward the invoice or statement of charges in three copies and insure that the signature and title of the provider or his representative appears on this document.

The Army concludes with this reminder: "It is important that the program for payment of civilian medical claims generated by active duty Army members not be confused with the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS). The CHAMPUS Program is designed to assist dependents (spouses and children) of active duty members, retirees, and their dependents, etc. The active duty Army member is not a beneficiary under the CHAMPUS Program. Much of the delay in receiving payments can be avoided if the providers are aware of this and discontinue the practice of submitting claims for active duty Army members through CHAMPUS." ▪

STATE RENEWS EMPLOYE HEALTH INSURANCE CONTRACT

The State of Wisconsin renewed its employe health insurance contract with Wisconsin Physicians Service (WPS) for another 18 months, ending Dec 31, 1978. The contract covers more than 100,000 state employes and dependents in Wisconsin.

SMS FAVORS CHANGES IN LIABILITY LAWS

The State Medical Society went before the Legislature last month endorsing legislation which provides for voluntary binding arbitration as one means of settling professional liability disputes. Under the proposal, a physician and patient would have the option of signing a "pre-service agreement" which would voluntarily bind them to the arbitration process should a dispute occur later. Under the process, a panel of experts would issue a finding in the case, which would be subject only to a limited judicial review. There would be no initial courtroom trial. The voluntary binding arbitration process would provide an alternative to the Patient Compensation Panels, where one or more parties may modify or reject the findings of the Panel. Appearing before the Assembly Insurance and Banking Committee, Frederick Kriss, MD, Madison, chairman of the SMS Ad Hoc Committee on Professional Liability, said, "The elements of speed, economy, informality, finality, and equity through the use of diverse panelists are incorporated into this bill."

Doctor Kriss also supported Assembly Bill 704, which: (1) Changes the continuing medical education requirement from 15 hours per year to 45 hours over a three-year period, with the State Medical Examining Board given the authority to increase it to 90 hours over the three-year period. (2) Authorizes the Commissioner of Insurance to establish supplemental health care liability insurance plans to add to primary coverage offered by private insurers. (3) Transfers responsibility for administration of medical professional liability provisions from the State Department of Regulation and Licensing to the State Department of Health and Social Services and to the Commissioner of Insurance.

PHYSICIAN LIAISON WITH THE HSAs

Physicians in eastern Wisconsin have taken the lead and formed a liaison committee with Lake Winnebago Area Health Systems Agency. It is believed to be the first full-scale physician liaison committee with an HSA in Wisconsin. The physician membership of the committee includes the chiefs-of staff of every hospital in the HSA area; every county medical society president; every SMS officer or councilor in the area; and all physician members of the HSA itself. The effort is being coordinated by the SMS Physicians Alliance field consultant Mike Brozek.

NEW FIRM TO PROCESS MEDICAID CLAIMS

The State of Wisconsin plans to negotiate with Electronic Data Systems-Federal, Inc (EDS-F) of Dallas, Texas, for the contract to administer claims for the Wisconsin Title 19 (Medicaid) program. EDS-F was selected by a special State Department of Health and Social Services committee which reviewed the bids submitted by four firms to process the Medicaid claims. The current fiscal agents for the program, Wisconsin Physicians Service (WPS), Surgical Care-Blue Shield, and Wisconsin Blue Cross, have held the contract since the Medicaid program started in 1966. The State terminated the contract with the existing fiscal agents in April, opening the contract for bidding to "insure the most effective expenditure of state and federal monies." ■

the wisconsin medical journal

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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HELPING THE RETARDED, DEVELOPMENTALLY DISABLED PERSON

The family physician is very often the first person a family turns to when they suspect their child may be retarded.

A resource the physician may wish to use in counseling the family is the local Association for Retarded Citizens. And a call to the local Unified Board or Developmental Disabilities Board will identify the resources that are available to a family.

There should be local resources, psychological services, OT, etc available to complement the physician's examination. Also there are several clinics within the state that provide specialized evaluations for the retarded and for persons with other developmental disabilities.

- CHILD DEVELOPMENT CENTER

  Dr June Dobbs, Director
  Milwaukee Children's Hospital
  1700 West Wisconsin Ave
  Milwaukee, Wisconsin
  (414) 344-7100

- UNIVERSITY HOSPITALS

  Dr Charles Schoenwetter
  1552 University Ave
  Madison, Wisconsin 53706
  (608) 262-9983

- WAISMAN CENTER ON MENTAL RETARDATION

  Linne Cain, Intake Coordinator
  2605 Marsh Lane
  Madison, Wisconsin 53706
  (608) 263-5776

- COMPREHENSIVE EVALUATION CLINIC FOR MULTIPLI-HANDICAPPED CHILDREN

  Ms Marilyn Gratto
  Miller-Dwan Hospital
  502 East 2nd Street
  Duluth, Minnesota 55805

Further information may be obtained from Robert Wilcox, Wisconsin Association for Retarded Citizens, Inc, 2700 Laura Lane, Middleton, Wis 53562; (608) 831-3444.

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LESLIE G KINDSCHI MD, Monroe
T H McDONELL MD, Waukesha
PHILIP J DOUGHERTY MD, Menomonee Falls
RAYMOND A McCORMICK MD, Green Bay
—*Editorial Associates*

$2,250,000 Savings

LAST MONTH there appeared a rather spleeny editorial about the unnecessary commission for insurance agents under the Wisconsin Health Care Liability Insurance Plan. Although nothing has been done about this specific complaint, the Board of Governors for the WHCLIP has recently approved a reduction in premiums for the next rate period.

In addition to the 15% reduction in premiums, there is a 50% reduction in the assessments for the Patients Compensation Fund (the umbrella coverage), and the Board of Governors also eliminated the surcharging for malpractice suits filed against physicians.

This amounts to a yearly reduction for physicians' premiums in the State Plan of $1,200,000, a yearly saving due to dropped surcharge of $50,000 and a yearly saving for Fund assessments of $1,000,000. The total is $2,250,000. The Board of Governors is to be commended for its prompt action, and the policy holders in the plan are grateful to the staff of the Physicians Alliance Division of the State Medical Society for its efforts in this direction.—VSF

A Healthy Alternative

IF WE IN ORGANIZED medicine say "no" to any form of National Health Insurance, we're going to be outshouted, outdone—and perhaps undone—by the labor-liberal crowd that has a strong "yes."

Certainly the Carter Administration will have a "yes," once three preconditions are met. These preconditions are reorganization of the Department of Health, Education, and Welfare (already initiated), welfare reform (for which a task force has been named), and cost controls (as embodied in the proposed ceiling, or "cap," on hospital-cost increases).

Proof of the Administration's commitment to NHI is furnished by HEW's appointment of an Advisory Committee on National Health Insurance issues. The 29 public members include Edgar T Beddingfield, MD, chairman of the AMA Council on Legislation, but also two outspoken labor leaders—President Leonard Woodcock of the United Auto Workers and Bert Seidman of the AFL-CIO—plus other liberals.

In announcing the appointments, HEW Secretary Joseph A Califano Jr said NHI "is a cornerstone in the structure of the President's domestic policy."

So we can be on the lookout for the Administration to offer an NHI proposal next year—and strive to get it enacted before the 1980 elections.

This proposal, if not basically a facsimile of the Kennedy-Corman-labor NHI bill, is likely to defer to its principal elements—the way the 1976 Democratic platform did.

What is the best way—really the only way—to head off this danger?

Well, no less conservative a US Senator than John G Tower of Texas has stated, "The most viable means of avoiding the Kennedy-Corman version of socialized medicine is to oppose it with more reasonable alternatives."

And as Congressman Paul G Rogers of Florida—an influential figure in health-care legislation—has said, "It is my view that to simply oppose legislation without offering alternatives rarely is an effective approach on Capitol Hill."

The American Medical Association's comprehensive health insurance measure is the reasonable alternative.

The AMA recognizes that most of the general public (the ultimate arbiter on the issue) wants an NHI bill. The majority, according to a recent Gallup Poll, want a form of it that is largely free of federal involvement and funding. A plurality—39 percent of the people polled—want a version that tallies pretty much with the AMA bill.

The AMA measure would preserve the private thrust of care and its financing. It would depend principally on employer-employe contributions and apply federal funds only to the poor and jobless. These funds, mind you, would come from general revenue—not from any special levy, like the already runaway Social Security tax.

In short, here's a bill that would preserve our professional freedom while honoring the public's wants and needs. We can't let the labor-liberal forces have the NHI ball to themselves. We have to be on the field fighting for it—and fighting as a great, strategic team. —JOHN P MULLOOLY, MD

Council Award

STATE MEDICAL SOCIETY OF WISCONSIN

Annual Meeting • Milwaukee • May 9, 1971

Presentation made by E. J. Nordby, M.D., *Chairman of the Council*

The highest honor in the power of the State Medical Society of Wisconsin to bestow is the Council Award. It is granted only upon occasion, and with rare exception to one other than a physician. In the 42 years since it was established, 36 awards have been made. Of those who have been its recipients, it may be said that they have personified the highest ideals in their devotion to the public good. Today, by direction of my fellow Councilors, we give another Council Award.

Charles H. Crownhart

A native of Superior, the son of a lawyer who was a noted member of the Wisconsin Supreme Court and a mother who for many years served as the Superintendent of Schools in Douglas County and as a member of the Board of Regents of the State Normal Schools, Charles Crownhart moved to Madison at the age of seven.

Following graduation from the University of Wisconsin and its law school, where he became a member of Chi Phi social fraternity, and Phi Alpha Delta legal fraternity, he began his own private law practice, later to be known as the firm of Crownhart and Murphy. He was also active as a member of the Progressive State Central Committee and in the professional affairs of the Bar.

During this time he married Marion Palmer and this union produced four daughters, Maryann, Sally, Virginia, and Gretchen.

Mr. Crownhart's association with the medical profession began under the wise tutelage of his late brother George, who was the Society's first full-time Secretary. "Charlie," as he is affectionately called, served as legal counsel and legislative representative for the Society until he was elected Secretary in 1942.

Secretary Crownhart or "Mr. C.," as he has been known by his staff, often described himself as the office boy to the state's many doctors. He is in fact recognized as an individual who has given outstanding impetus and leadership to any endeavor he has ever undertaken.

He is a charter member and past president of the American Association of Medical Society Executives, a fellow of the American Public Health Association, and a member of the American Judicature Society. In the past he served as a member of the Board of the Associated Medical Care Plans, now the National Association of Blue Shield Plans.

Under his direction, the Society's present medical care plan, WPS–Blue Shield and the usual, customary and reasonable fee concept were founded. The Charitable, Educational and Scientific Foundation, which operates the Museum of Medical Progress as well as many other charitable and scientific programs, was initiated. The SMS Realty Corporation which operates the "Home" of the Society in Madison was begun. All of these have become recognized nationally as methods of implementing projects of lasting value to the public and the profession.

Many other contributions have been credited to this lawyer who has been described as a man who doesn't forget family, doesn't forget friends, doesn't forget principle, and doesn't forget goals.

These words, written by Mr. Crownhart in 1942, summarize the foresighted philosophy which has enabled him to render unstinting service to his profession, to the medical profession, and to the public:

> "Let us appreciate that the free competitive spirit of the American people permits no domination of self-thought or independence. Let us give heed not alone to the accomplishments of medicine and of our social structure, but to the freedom with which they are available to each of us. And to them attach a true sense of values that, as we approach an era in which our nation may be instrumental in securing a form of ultimate peace and tranquility throughout the world, we may place each of our endeavors in its proper niche of importance."

Mr. Crownhart, we give you this Seal of the Society as a token of your achievement on our behalf and in appreciation for your steadfast adherence to and understanding of the principles of our profession, as well as your dedication to the health of the people of Wisconsin and the nation.

Reproduced for this dedicatory issue in memory of Charles H Crownhart

Charles H Crownhart
1905-1974

A Tradition Kept

THIS SPECIAL ISSUE of the *Wisconsin Medical Journal* has been made possible through the expressed wish of Mrs Charles H Crownhart of Madison, that contributions to the Society's Charitable, Educational and Scientific Foundation (CESF) in memory of her late husband be put to some use that exemplifies the true spirit of his many years as secretary of the State Medical Society of Wisconsin. The dedicatory BLUE BOOK issue of the *Wisconsin Medical Journal* certainly does so, both in spirit and in fact.

The BLUE BOOK emerged as an annual issue of medical-legal importance to physicians during the time that Charles Crownhart's brother, George, was secretary. In the late 1940s and early 1950s Charles enlarged and enhanced the BLUE BOOK as an instrument of physician education, a guide-book to be kept and used to cope with the growing intricacies of medical practice, law, and administrative medicine.

Charles was a lawyer whose love of the law and medicine moved his every professional act. We hope that this issue is worthy of the spirit and dedication of the brothers Crownhart to whom the Society owes this fine tradition in medical-legal journalism.—ERT

Welcome Aboard

AT THE RECENT Annual Meeting the Council of the State Medical Society appointed two new members to the Editorial Board of the *Wisconsin Medical Journal.* One of the new members is Harold H Scudamore, MD, of the Monroe Clinic. He is an internist and his appointment maintains continuity since he is taking the position of Dr Leslie Kindschi from the same clinic. The other new member is Richard D Sautter, MD, thoracic surgeon with the Marshfield Clinic. This appointment re-establishes a long-term connection with the Marshfield Clinic, as a series of three medical editors covering a span of 25 years were all from the Marshfield Clinic.

The Staff and Editorial Board of the *Wisconsin Medical Journal* heartily welcome the two new members to the Editorial Board.—VSF

Doctor Kindschi—17 Years on the Editorial Board

IT WAS WITH real regret that we received the news of Dr Leslie Kindschi's resignation from the Editorial Board after 17 years of service.

In reading his comments relative to articles submitted for consideration by the *Wisconsin Medical Journal,* I often wished that the authors wrote as well as Doctor Kindschi. These comments, usually scholarly, sometimes sharply barbed, should have been collected and published themselves. One I recall that was directed to professorial authors from an unnamed medical school stated: "Obviously, this will have to be rewritten in English."

The Editorial Board and the Staff join in thanking Doctor Kindschi for the 17 years of service to the *Wisconsin Medical Journal,* and we all hope that he has enjoyed the association as much as we have. We will certainly miss him on the Board and hope that he may be available for occasional editorial consultations in the future.—VSF

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Chaplet for Charlie

Reprinted from
Wisconsin Medical Journal
January 1964 issue

EVEN A QUICK look at the literature published by the American Management Association produces a deep impression of the necessity for developing executive talent. Private commercial organizations spend hundreds of thousands of dollars on systematic programs for recruiting or developing managerial capability of an executive calibre. Fortunate indeed is the organization, commercial, philanthropic or professional, that has at its head a chief officer who can fill the role of an executive with skill, devotion, and unquestioned loyalty to the principles of the group.

Fortunate, indeed, is the State Medical Society of Wisconsin with Charles H Crownhart as its executive officer. In the kind of office that often attracts the well-meaning ineffective who finds himself uncomfortable in the competitive environment of private enterprise, we have a man with the capability to administer a commercial establishment of vast complexity. Among professional organizations, we are outstanding for the vigor of our programs, for the vitality of our growth, and for the community-oriented liveliness of our activity. A large part of whatever praise we receive as an organization is due to Charlie Crownhart's skill as an executive.

For the job of an executive officer of a medical society is not an easy one. Crownhart cannot give orders as would the boss in a private organization. He must persuade and convince. He must exhort and enthuse professional men who would just as soon devote their leisure time to their own families or their personal hobbies. Yet he must solicit member service without sacrificing his own dignity nor that of the society. This calls for a high degree of personal charm and magnetism.

But important as it is, a cordial personality alone does not make a successful executive. The administrator of any organization, and particularly of a professional organization, must have an idea for the direction of the enterprise. He must have a realistic appraisal of what the organization stands for today and where he thinks it ought to be a decade or two in the future. He must have the ability of translating that concept into practical activity and of persuading those responsible for the articulation of policy that his vision is the right one for the group. Without this kind of vision and its implementation, our own society would be a dispirited, listless group engaged in the meaningless carbon-copy activities of national medical groups. That we are uniquely a *Wisconsin* society is a tribute to Charlie Crownhart's vision and efficiency as dedicated administrator of our society.

Leadership is a lonely function. It's a sobering experience, and one that requires prudence, tact, and sensitivity. No utterance is casual; no action can be whimsical or capricious. The discipline of leadership is a terrible one, and it requires strong character to stand up to the responsibility that comes with the exercise of authority.

Ralph J Cordiner, chairman of the Board of the General Electric Company, made this pertinent observation about "the Chief Executive:" ". . . he cannot allow himself to become a mere reed, bending before every current of popular opinion. Because of his position of responsibility, he must be willing to stand and be judged on matters of principle—even though this may, on occasion, make him temporarily unpopular with his associates or with the public . . . and he will probably find his satisfactions in other ways—not popularity. Time has a way of winnowing out the trimmers and resting its longer verdict with men who have tried to maintain personal standards of integrity."

When it comes to counting our assets as a professional society, chief among them should stand the name of Mr Charles H Crownhart, our secretary. —DNG □

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NEWSWEEK IS READ by large numbers of the American public. Within the past few months it has run two full-page editorials concerned with the status of physicians. On January 10 Maurice Fox, MD of Palo Alto, wrote on "Why People are Mad at Doctors." All charismatic persons become used to the double prong of hostility which nearly always accompanies positions of power; physicians by our very profession have long known this.

Doctor Fox was identifying only one half of this ambivalence, namely the anger that doctors "don't listen sufficiently" and that doctors "make too much money." His handling of these points reads well. But on March 28, Charles Peters, editor of the *Washington Monthly,* occupies the same prominent page in *Newsweek:* "A Radical Cure for High Medical Costs," in which he states simply that the American public deals with all other life-saving professions, listed in title, by basically a civil service, salaried system. There is just no reason, he says, why physicians should not be so paid and allocated. He mentions the physician who cannot "afford" to take Medicare patients (a quote which is unfortunate but sometimes accurate), and physicians who seem to believe the problem of public medical coverage can only be solved by paying the fee he has been used to charging. And comparisons are made with Britain, and with the military medical service system.

He also treats rather harshly the "indecent wealth" of some physicians; not mentioned, but suggested, is the sometimes rather blatant public display of wealth: new foreign cars in doctors' parking lots, and the like. At least the issue has been stated clearly. Your SMS mailed a copy of this March 28 editorial to me (and to other members) even before I had time to tear out my own *Newsweek* copy. Let's try to meet the issues and the needs without resorting to the fatal errors of some portion of our membership who see their own gain in such a manner as to aggravate decisive writing, such as is now beginning. Since it will continue, likely increase, we had better think through our position, to avoid being too easy a target; sadly the target stance comes so easily.—RH ▪

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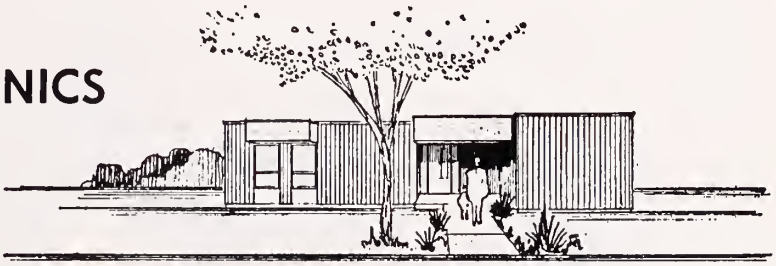

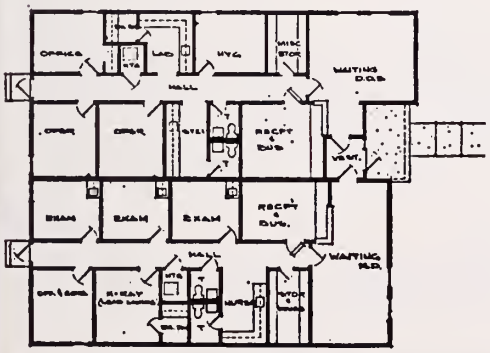

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Council approves program to help the impaired physician

The SMS Council, meeting June 4 in Madison, approved a new approach for dealing with the impaired physician —the doctor suffering from alcoholism, other drug dependency or mental illness.

The Council authorized the newly named Commission on Mediation and Professional Ethics to serve as the focal point for any problems involving an allegedly impaired physician. The new approach has been named the Impaired Physician Program.

Upon receiving a request for assistance, from the physician himself, a colleague, hospital official, family member, or patient, Commission officials will meet to determine if the complaint appears to be legitimate.

One member of the Commission will be designated by the Chairman to approach the impaired physician. The Commission member will be accompanied by a consultant, selected by the Chairman on the basis of the nature of the complaint.

The two designees will interview the impaired physician, citing the nature of the alleged impairment and the concerns of colleagues, family members, and others. During the discussion, the visiting team will offer appropriate recommendations for dealing with the problem.

The team will maintain a liaison with the full Commission, informing members of the progress of the impaired physician in the recommended program of therapy or rehabilitation. In the event the physician refuses to accept the interview or to undertake or continue the recommended therapy or rehabilitation, the full Commission will take appropriate action, depending upon the circumstances of the individual case.

Members of the SMS Commission on Mediation and Professional Ethics include: MDs Gerald C Kempthorne, Spring Green, chairman; Brian T Coffey, Racine; Herman J Dick, Sheboygan; Charles E Koepp, Marinette; Owen E Larson, Neenah; Bernhardt E Stein, Madison; John Wear Jr, Madison; G John Weir Jr, Marshfield; and Harry F Weisberg, Milwaukee.

A complaint alleging that a physician is impaired may be made by contacting the Commission on Mediation and Professional Ethics, State Medical Society of Wisconsin, Box 1109, (330 East Lakeside St), Madison, Wis 53701. The telephone number is 608/257-6781.

All complaints will remain confidential. ■

Society sponsoring trip to Ireland

How are things in Glocca Morra?

Now you have an opportunity to find out for yourself by joining the SMS tour to Ireland.

The tour, round-trip from Milwaukee, begins Sept 5, 1977 with participants returning September 13.

The package offers physicians interested two options. First, for those with an independent style, there's the Ireland Holiday by Car, for $599. This includes round-trip transportation, a car for a full week, lodging in a first class hotel, breakfast daily, Irish Holiday escort service, and more.

And, there's the Ireland Scenic . . . by Bus, for $679. This will provide an in-depth look at the countryside and larger cities of Ireland. Here, you'll tour Ireland by bus with an experienced tour guide and stay at various first class hotels. Also included in this package is breakfast and dinner each day, sightseeing and entrance fees for the entire itinerary, and more.

All SMS members received a brochure describing the trip with the May issue of the Medical GREEN SHEET. For more information, contact the travel agents handling the tour: Dittman Tours, Inc, Box 199, Northfield, Minn 55057. ■

No group-buying cooperative at this time

The SMS Council, acting upon the recommendation of the Finance Committee, has decided the Society should not now develop a group purchasing cooperative plan for members.

The Society had contracted the services of a firm to survey physicians to conduct a feasibility study. The firm recommended against the idea, at this time, "since acceptance and use by members appears to be very questionable and a failure could be devastating to the Society."

Instead, the Finance Committee recommended that the Council proceed "as rapidly as possible toward development of a more comprehensive membership services corporation which could, at some future date, include such a purchasing benefit." ■

H/D Nominating Committee to meet Sept 25, Madison

The next formal meeting of the SMS House of Delegates Nominating Committee will be at 10:00 AM, September 25, at SMS offices in Madison.

Chairman of the committee, Dr John D Riesch of Menomonee Falls, says, "Now is the time to approach your individual Society members and county medical society as a whole to bring forth candidates and curriculum vitae, etc. Please send all of this information as soon as possible to the SMS office."

The offices for which nominations will be presented to the House of Delegates in April 1978 include: President-elect 1978-79; Vice-speaker 1978-79; and AMA Delegates and Alternates for calendar years 1979-80.

Current AMA Delegates include MDs John E Dettman, MD, Green Bay; George E Collentine Jr, Milwaukee; and DeLore Williams, West Allis. Alternate AMA Delegates include MDs George A Behnke, Kaukauna; Harold J Kief, Fond du Lac, and Patricia J Stuff, Bonduel. ■

SMS Variable Annuity Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.32 as of April 29, 1977. ■

COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

April 13, 1977 — Milwaukee

1. Call to Order and Roll Call

The meeting was called to order by Chairman Correll at 1:30 pm on Wednesday, April 13, 1977, at the Marc Plaza Hotel, Milwaukee.

Voting members present: Chairman Correll; Vice-chairman Edwards; Doctors Pittelkow, Williams, Boulanger, Schmidt, JJFoley, Nielsen, Bruhn, LaBissoniere, Mullooly, Huth, Tuftee, Waterhouse, Rohde, Kief, Lewis, Peters, TFFoley, Smejkal, Haskins, Doyle; President Picard, President-elect Larsen, Speaker Stuff, Vice-speaker Motzel.

Others present (part or entire): Doctors Nordby, Derus, Twelmeyer, Collentine, Dettmann, Scott, Levin, Behnke, Erwin, Bernhart, Goldstein; Mrs Schaeffer; Dr and Mrs Charles Lyons; Messrs Thayer, Maroney, Simms, Jensen, Nelson, Johnson, Fetherston, LaBissoniere, Stromer, Koenig, Lockerbie, Schweers, Smolker, Brodersen, Brown; Mrs Bartel and Miss Pyre.

2. Approval of Minutes of March 5, 1977

Approved on motion of Doctors Picard-Pittelkow, carried.

3. Conflict of Interest

On motion of Doctors Haskins-Mullooly, carried, the Council adopted a new Statement of Policy on Conflict of Interest and individual certificate to be executed annually by councilors, officers, chairmen of commissions, and employees holding positions of responsibility. The former statement included members of the WPS Commission who are not mentioned in the new statement since WPSIC will have its own conflict of interest procedure.

4. Annual Reports of Councilors

Reporting informationally on behalf of the several councilor districts were Doctors Schmidt, Huth, Rohde, Lewis, Peters, Smejkal, Haskins, and Doyle.

The Council by acclamation recognized the conscientious work as councilors of Doctors Huth and Rohde who were completing three terms of service.

5. Report of the Treasurer

Doctor Nordby commented on the annual report of the treasurer prepared for distribution to the Council and House of Delegates.

The report was accepted by the Council.

6. Report of President of Auxiliary

Mrs Bernard Schaeffer reviewed the past year's activities and growth in Auxiliary membership, and distributed a copy of their convention folder containing reports of state and county auxiliary activities.

On motion of Doctors Picard-Edwards, carried, the Council commended Mrs Schaeffer, the other officers and Auxiliary membership for their fine work.

7. Commission on Public Information

A. Proposed Communications Guide

Mr Fetherston presented a proposed "Communications Guide for Wisconsin Hospitals and Physicians—Responsibility to Patients" developed out of many meetings between the Commission and the Wisconsin Hospital Association.

There was discussion of a section on "newsworthy persons" such as those in public office which states that to some extent they have surrendered the right of privacy and suggests procedures for issuing information on the patient's condition. The paragraph was generally accepted with the advice that the physician has the right to say "no comment" or refer the media to the family or have any bulletins cleared with the family.

The Hospital Association had proposed the addition of a sentence under "interviews and photographs" to read: "Patient access to the news media is a basic human right." The Council approved a revision of this sentence to read: "Access to the news media is a prerogative of the patient."

The Council requested an additional amendment in paragraph two under "hospital and physician relationships with the news media," inserting the underlined words in the following sentence: "Although reporters judge what is news, the hospital, the physician, *and the patient when appropriate*, as a team, are the competent judges of what serves the patient's best interest."

On motion of Doctor Smejkal, seconded and carried, the guide was approved as amended.

B. Brochure "To Your Good Health"

A brochure with health tips and explanation of increases in the costs of medical care, developed under direction of the Commission on Public Information, was distributed to the Council. It will be made available to the membership to order for use in their offices.

8. Statement on Thermography

On recommendation of the Committee on Cancer, the Council, on motion of Doctors Edwards-Smejkal, carried, approved the following revision of a previously adopted statement on thermography:

> In the detection of cancer of the breast, the State Medical Society of Wisconsin warns the public against thermography when used as a sole diagnostic or screening tool. It is felt, in light of the current nondiscriminate level of positives, as well as the high incidence of false negatives, thermography potentially can give the patient a false sense of security leading to delays in seeking evaluations which could avoid the unfortunate consequences of late diagnosis.
>
> The most effective type of breast cancer detection available at the present time is regular monthly breast self-examination combined with periodic health examination by a physician. Mammography and xerography should be used as indicated in the individual case.
>
> Patients are strongly encouraged to work closely with their personal physicians in all health care problems, including physical examinations, on a regular basis.

9. WPS Fee Reimbursement Freeze

The Council reviewed correspondence from several sources concerning implications of the 1975 fee reimbursement freeze instituted to aid the financial condition of WPS, and subsequent actions by the Council and House of Delegates in 1976 stating conditions under which fee level increases would be permitted, following the lifting of the freeze, effective May 1, 1976, and subsequently.

Doctor Waterhouse, speaking as chairman of the Claims Committee of the WPS Commission, asked that flexibility be given to that committee in the matter of fee increases.

He moved that the Council allow the WPS Claims Committee to apply the intent of the previous fee freeze based on their best judgment and discretion as it relates to timing of fee increases and requested dates; seconded by JJFoley.

Doctor Nordby maintained that allowing increases effective retroactively to January 1, 1977, for example, as several groups have requested, would in effect negate the entire fee freeze which initially was authorized to continue through 1976, but because of the good effects was lifted as of April 1, with increases meeting the conditions to become effective May 1, 1976, and no more often than 12 months from the date of any increase thereafter.

After further discussion, the motion lost by a vote of 14-9.

Prior to adjournment, a motion by Doctors Stuff-Edwards that this action be reconsidered failed to carry.

10. Approval of County Society Constitutions and Bylaws

Mr Maroney reported that revised constitutions and bylaws had been submitted by Eau Claire-Dunn-Pepin, Ashland-Bayfield-Iron, and Pierce-St Croix county medical societies.

On motion of Doctors Smejkal-Kief, carried, the Council gave its approval subject to minor corrections being made to remove any inconsistencies with the Constitution and Bylaws of the State Medical Society.

He indicated that the model constitution and bylaws for county societies approved by the Council several years ago needs updating to incorporate certain amendments adopted in the SMS bylaws.

On motion of Doctors Edwards-Smejkal, carried, the Council requested that a new model be prepared for review at a future meeting.

11. Request for Specialty Section Status for Emergency Physicians

On motion of Doctors Smejkal-Schmidt, carried, the Council approved and recommended that the House of Delegates approve the creation of a Section on Emergency Medicine.

12. Committee on Economic Medicine

Doctor Schmidt reported that the committee had looked into a question raised at a Council meeting by Doctor Williams as to private pension plans available to physicians as an alternative to Social Security, indicating that they do not have the option to "get out" of Social Security, and that groups that have done so will apparently be brought back in by federal intervention.

The committee received a presentation by Mr Frank Thatcher of Seefurth-McGiveran, member insurance plan consultant, on a "medical reimbursement plan" for health care expenses not covered by insurance which physicians or service corporations may set up under the internal revenue code. The availability of such a plan will be publicized to physicians with advice that they contact their business advisors.

The committee considered possible sponsorship of a medical office protection package. Based on research by Mr Thatcher, the committee decided against sponsorship since much of the package would be duplicative of existing property and liability insurance.

The committee received the 12th annual report prepared by Seefurth-McGiveran on the Society-sponsored plans, which was summarized for the Council by Doctor Schmidt.

13. Finance Committee

Doctor Edwards reported that the committee reviewed budget-expense reports for 1976 and through March 1977. Final 1976 expenses were under budget by $51,000. Expenses through March are under the budget in total, though some items such as legal counsel are considerably overexpended, and it is expected this will continue throughout the year as a result of the medical defense activity, Title 19 lawsuit, and amicus curiae action on the professional liability law. The committee also discussed the problems resulting from having three law firms involved in various Society activities.

The committee met with representatives of the firm retained to conduct a feasibility study on a group purchasing plan, and concurred with their conclusions that this is not the right time for the Society to enter such a plan. Instead, the committee recommended that the Society proceed as rapidly as practical toward developing a more comprehensive membership services corporation which could, at some future date, include such a purchasing benefit.

The status of the reserve account was noted, as well as the amount of dues received to date, with 329 more members having paid full dues than at the same time a year ago. The committee received a complete set of audit reports which will be discussed at the next meeting.

The committee discussed the question of dues for 1978, and acknowledged the 1975 House action that dues are to be adjusted annually to recognize the effects of inflation on the budget, the combined 1975 and 1976 inflation rate being 13%. At the same time, increased membership is anticipated over the

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next few years which will result in additional dues income. It therefore recommended that 1978 dues remain the same as in 1976 and 1977, $300.

On motion of Doctors Edwards-Waterhouse, carried, this recommendation was forwarded to the House of Delegates.

Meeting as the Managing Committee and Trustees of the SMS Employee's Pension Plan, some administrative matters were handled and action was taken to allow WPSIC (when separately incorporated), SMS Realty Corporation, and Wisconsin Health Care Review, Inc employees (excluding WisPRO), to participate in the Plan provided an adequate indemnification agreement is executed.

On motion of Doctors Edwards-Williams, carried, this action was approved.

On motion of Doctors Huth-Waterhouse, carried, the report was accepted in total.

14. WPS and WPSIC

A. Status report on incorporation

Mr Thayer reported that the Commissioner has indicated he expects to deal with the question of final approval of the application "momentarily."

B. WPS Commission

Mr Koenig, asking for any questions on the printed annual report to the Council and House of Delegates, gave status reports on the question of bidding on the Title 19 specifications and on the state account renewal.

15. Report of the Nominating Committee

The Council acted on recommendations of the nominating committee in making appointments or reappointments for expired terms and vacancies on commissions and committees of the Society.

[NOTE: The composition of commissions and committees with indication of terms expiring in 1978, 1979 and 1980, will appear in the June issue of the *Wisconsin Medical Journal*.]

In reference to the WPS Commission, the committee reported it had been informed by the Insurance Commissioner that he would not approve of changes in the initial WPSIC board at this time. The proposed changes were presented to the Council for decision. Mr Thayer explained that the nominating committee's recommendations were made in good faith to reduce the number of physicians on the WPS Commission to conform with the number specified for board membership in the WPSIC incorporation documents.

The Council's concern was with the implications of the Commissioner's stance on the future authority of the Council with reference to the appointment of WPSIC board members. It also desired information on what WPS representatives had informed the Commissioner that the Council was "tinkering" with the board composition.

After considerable discussion, Doctors Mullooly-Boulanger moved that the recommendations of the nominating committee be adopted.

Doctors Lewis-Waterhouse moved that the question be tabled until the Saturday Council meeting and that the Commissioner be contacted in the interim. Motion carried.

With reference to the Commission on Governmental Affairs, the Council approved the following provision relative to representatives of specialty sections on motion of Doctors Mullooly-Huth, carried:

"Membership of the Commission on Governmental Affairs shall include a representative from each of the specialty sections of the Society. These representatives shall be appointed by the specialty sections annually. Such appointments shall be subject to the approval of the Council. Representatives on the Commission from the specialty sections need not be counted for purposes of a quorum for a meeting of the Commission on Governmental Affairs, but shall have the right to vote."

The nominating committee also proposed some recommendations to the Governor for appointment to the Medical Examining Board, and recommended that the matter be held for the Council meeting on Saturday for consideration of additional nominees.

★

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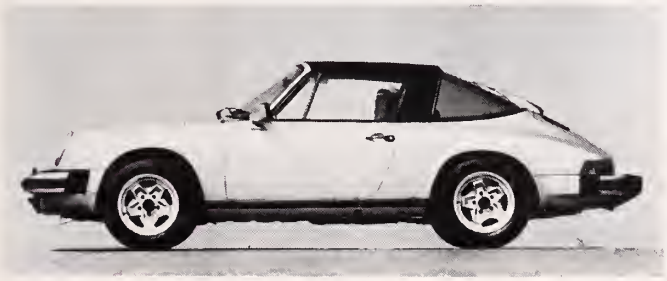

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16. Report of Executive Committee

A. Milwaukee Journal "sore throat" series

The committee has encouraged the Secretary to submit a protest to Sigma Delta Chi, the professional journalism society, concerning the Journal series.

B. Appointment of CPA Consultant

On motion of Doctors Picard-Edwards, carried, the Council approved the appointment of Donald E Gill & Company firm as the Society's CPA consultants for the ensuing year.

C. Council Retreat

This was held for discussion at the Saturday meeting with the "new" Council.

17. Report of Physicians Alliance Commission

A. Title 19 Provider Contract

Mr Thayer reported that in several meetings with DHSS representatives the latter have refused to discuss the terms of reimbursement. Other contract provisions are under continuing negotiation.

B. Title 19 Certification/Decertification

Hearings and negotiations are also being held on these proposed rules, which most of the providers feel are an unnecessary addition to an acceptable provider contract.

C. Suit Challenging Constitutionality of State Professional Liability Law

The Council had received information concerning a suit brought by Attorney Kirkhuff of Madison. It was reported that Mr John Kluwin had been retained by the Society to prepare a brief amicus curiae for submission at the appropriate time. Attempts are being made to secure commitments from other interested organizations to share the legal expense.

D. Wisconsin Health Care Liability Insurance Plan

The Council was informed of recommendations which will be made to the board of governors by the actuarial subcommittee on reduction of premiums and elimination of the surcharge.

18. Report of Commission on Governmental Affairs

The Commission requested Council approval for the appointment of a Committee on Environmental Health which would examine environmental legislative proposals for their impact on health.

Question was raised as to the necessity of establishing another committee with fiscal implications. Doctors Pittelkow-Stuff moved that the existing occupational health committee be expanded to occupational and environmental health.

The chairman suggested that the Commission take up this proposal with the Committee on Occupational Health to determine the interest and expertise to deal with environmental matters, and report back to the Council at a future meeting at which time the fiscal note could be considered. This was acceptable to the Council.

19. Adjournment

The chairman declared the meeting adjourned at 5:00 pm and, since it was his last meeting as a Council member, expressed his thanks and hope that organized medicine will remain viable and its efforts increasingly well coordinated in the future.

EARL R THAYER
Secretary

Approved June 4, 1977
PAUL S HASKINS, MD
Chairman

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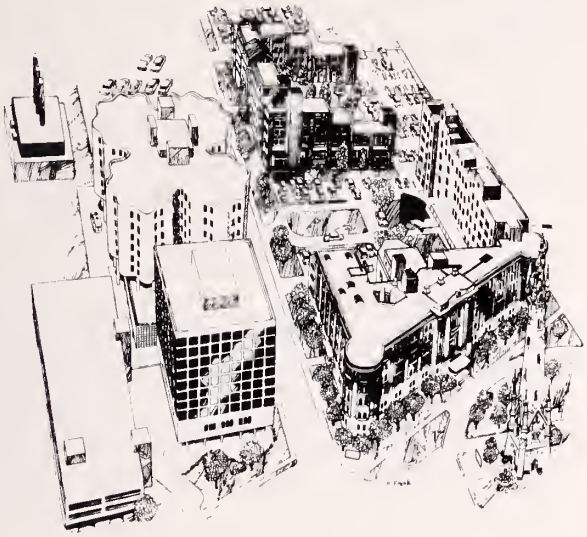

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COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

April 16, 1977 — Milwaukee

1. Call to Order and Roll Call

The meeting was called to order at 10:30 am on Saturday, April 16, 1977, at the Marc Plaza Hotel, Milwaukee, and was chaired initially by Doctor Correll.

Voting members present: Doctors Schmidt, Foley, Nielsen, Bruhn, LaBissoniere, Mullooly, Edwards, Tuftee, Waterhouse, Natoli, Kief, Lewis, Peters, Flaherty, Smejkal, Haskins, Doyle, Past President Picard, President Larsen, President-elect Levin, Speaker Motzel, and Vice-speaker Taebel.

Others present: Doctors Nordby, Derus, Williams, Scott, HJKief, Stuff, Huth, James, Wright, Grover, Biek, Goldstein; Messrs Thayer, Maroney, Simms, Jensen, Nelson, Brower, Fetherston, Johnson, Brown, Westbrook, Koenig, Bontrager, Lockerbie, Schweers, Smolker, Brodersen, Brozek, Murphy; Miss Pyre.

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2. Oath of Office

The oath was administered to Councilors Natoli and Flaherty, Vice-speaker Taebel, and later, upon his arrival, to President-elect Levin.

3. Elections

By various motions made, seconded and carried, the following were nominated and elected:

Chairman of the Council: Paul S Haskins, MD
Vice-chairman: R W Edwards, MD
Treasurer of the Society: E J Nordby, MD
Assistant Treasurers: A A Quisling, MD and H Kent Tenney, MD
Secretary: Earl R Thayer
Editorial Director: Raymond Headlee, MD
Editorial Associates: Doctors Boulanger, Mullooly, Kindschi, McDonell, Dougherty, and McCormick re-elected

Doctor Haskins took the chair and thanked the Council for the vote of confidence. He said he intended to ask for greater involvement by individual members of the Council in carrying out its responsibilities.

4. Annual Appointment of Consultants

On motion of Doctors Smejkal-Kief, carried, the Council reappointed Robert B Murphy legal counsel, and E Paul Barnhart, actuary.

5. WHCRI-WisPRO

On motion of Doctors Waterhouse-Kief, carried, the Council accepted and supported the following Statement of Intent:

It is intended that upon separate incorporation of Wisconsin Professional Review Organization, Inc (WisPRO), which has been a component of Wisconsin Health Care Review, Inc (WHCRI), the two will operate cooperatively in an effort to improve the effectiveness and extend coverage of health care review activities in the Greater Wisconsin PSRO area.

In this cooperative operation it is intended that WisPRO:

(1) Will retain full policy and operational control over all heath care review activities mandated by the federal government or made optional and compensated by the federal government under PSRO or any similar federal program in the Greater Wisconsin area.

(2) Will be the principal operational medical care review organization for programs developed or contracted for by WHCRI in the Greater Wisconsin area. WisPRO will perform this review activity on a subcontract basis from WHCRI and will be fully responsible for policy implementation and operational conduct under the subcontracts.

(3) Will not solicit review contracts other than PSRO mandated programs. If offered such contracts from other sources, WisPRO will coordinate its response to such offers and their implementation, if accepted, with WHCRI in order to attempt to integrate them, to the extent possible, with programs developed or contracted for by WHCRI.

In this cooperative operation it is intended that WHCRI:

(1) Will function in the Greater Wisconsin area as a multi-disciplinary organization whose primary function shall be to introduce the concepts of health care review and develop health care review programs, in those areas of health care not covered by federally

mandated and financed programs. This shall include the establishment of procedures and standards for programs it develops in conjunction with the appropriate operational review organizations; coordination of and assistance to operational review organizations; and service as a liaison between the public, those requesting review and the operational review organization.

(2) Will not conduct operational review activities except on a pilot project basis or in the event no operational review organization wishes to conduct a particular program.

(3) Will offer, on a subcontract basis, to the appropriate operational review organization the operation of review programs other than pilot projects.

On motion of Doctors Waterhouse-Kief, carried, the Council encouraged the WHCRI and WisPRO boards to act in an affirmative fashion on this Statement of Intent within approximately the next 30-45 days.

On motion of Doctors Waterhouse-Picard, carried, the Council asked the chairman to appoint two members from the State Medical Society and accept two members from WisPRO and two from WHCRI to meet together to discuss the actual implementation and reorganization that may be necessary to get on with the process, and report back to the Council at its next regular meeting.

6. Nominations

A. WPS Commission

On motion of Doctors Mullooly-Edwards, carried after discussion, the matter of nominations for the WPS Commission (WPSIC board of directors) remains tabled until the next Council meeting.

On motion of Doctors LaBissoniere-Picard, carried, the Council requested that the situation be further investigated.

B. Physicians Alliance Commission

On motion of Doctor Smejkal, seconded and carried, Joseph Diraimondo, MD, Manitowoc, was appointed to the unexpired term of Doctor Forbes (1978) representing the sixth councilor district.

C. Medical Examining Board

On motion of Doctors Mullooly-Picard, carried, the Council approved the nominations reported at the April 13 meeting for recommendation to the Governor.

7. Certificate of Need

Mr Jensen reported the details of agreements which had been reached with interested parties on certificate of need legislation.

8. Election of Nonmedical CESF Trustees

On motion of Doctor Edwards, seconded and carried, Messrs Robert B Murphy and George Kress were reelected, and Richland County Judge Kent C Houck was elected to succeed Judge Flom, deceased.

It was pointed out that there were two additional vacancies: James Morton Smith has left Wisconsin, and Warren E Clark of Milwaukee is ill and unable to participate. Mrs Richard Hartzell of Grantsburg was suggested as a potential trustee. On motion of Doctors Picard-Edwards, carried, Mrs Hartzell was nominated and the request made that she be contacted as to acceptance.

9. Council Meeting Dates

On motion of Doctors Schmidt-Mullooly, carried, the Council requested that the staff in consultation with the Chairman of the Council and the President set the program, date and location for the previously discussed Council "retreat," with the preference stated that such a meeting be held in late summer or fall.

June 4 was set as the next meeting date, and other meetings were at least tentatively set for August 6, October 8, December 10, February 4, and just prior to the April 1978 annual meeting.

10. Howard L Correll, MD

On motion of Doctor Waterhouse, variously seconded and carried, the Council expressed its heartfelt thanks to Doctor Correll for his excellent service as Council chairman.

11. Adjournment—11:30 am

EARL R. THAYER
Secretary

Approved: June 4, 1977
PAUL S HASKINS, MD
Chairman

■

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MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

CORRECTION

In the April 1977 issue of WMJ it was incorrectly stated that Ellet H Drake, MD, A Ward Ford Memorial Institute, Ridgeway Bldg, Maple Hill, Wausau 54401 was a pediatrician. As a new member of Marathon County Medical Society, Doctor Drake is a specialist in cardiovascular diseases and is certified. The WMJ regrets this error. Our apologies to Doctor Drake.

Membership Report as of April 26, 1977

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

DOUGLAS

Reibold, Robert J, 4007 N 21st St, Superior 54880 (1947, Regular, Internal Medicine, Certified)

LACROSSE

Arani, Ali G, 815 S 10th St, LaCrosse 54601 (1940, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)

Ford, Charles N, Jr, 1836 South Ave, LaCrosse 54601 (1940, Regular, Otorhinolaryngology, Certified)

Nelson, David Lee, 815 S 10th St, LaCrosse 54601 (1947, Regular, Pediatrics)

Shultz, Paul Stephen, 815 S 10th St, LaCrosse 54601 (1948, Regular, Pediatrics)

MANITOWOC

Stoune, John L, 600 York St, Manitowoc 54220 (1944, Regular, Internal Medicine/Rheumatology, Certified-IM)

White, Wayne F, 2300 Western Ave, Manitowoc 54220 (1933, Regular, Anesthesiology)

PRICE-TAYLOR

Kanca, Milan, 101 N Gibson Ave, Medford 54451 (1936, Regular, Pediatrics/Anesthesiology)

Sargeant, James G, 500 Birch St, Park Falls 54552 (1939, Regular, General Surgery)

Shah, Dinesh H, 101 N Gibson Ave, Medford 54451 (1948, Regular, Internal Medicine)

ROCK

Austin, John A, 2000 E Racine St, Janesville 53545 (1945, Regular, Internal Medicine)

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County Medical Society

DANE

Cooper, Garrett A, Green Valley, AZ, to 1512 Sumac Dr, Madison 53705

JEFFERSON

Arcilla, Senen S, Watertown, to 16525 Nancy Lane, Brookfield 53005

ONEIDA-VILAS

Litton, Eva W, Rhinelander, to 2451 Elaine St, Fayetteville, AR 72701

Litton, Murray A, Rhinelander, to 2451 Elaine St, Fayetteville, AR 72701

MILWAUKEE

Mullins, Margaret M, So Milwaukee, to Lankenau Hospital, Lancaster Ave, Philadelphia, PA 19151

Northey, Thornton M, Milwaukee, to 670 Warren Lane, Key Biscayne, FL 33149

Rabor, Antonio A, Jr, Greendale, to 19063 Highway 18, Apple Valley, CA 92307

DEATHS

Shippy, Vincent J, Brown County, Mar 7, 1977

Looze, Joseph A, Brown County, Mar 23, 1977

Killins, Wendell A, Brown County, Apr 14, 1977 ■

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OBITUARIES

◈County, State, AMA Members

◈ **Wallace L Nelson, MD,** 75, Wisconsin Rapids, died Dec 5, 1975 in Appleton. Born Jan 7, 1900 in Racine, Doctor Nelson graduated from Northwestern University Medical School in 1927. He had practiced in Wisconsin Rapids from 1932 until his retirement in 1970.

◈ **Judson S Allen, MD,** 88, Norwalk, died Feb 21, 1977 in Sparta. Born Sept 10, 1888 in St Lawrence, New York, Doctor Allen graduated from the University of Vermont and had practiced in Norwalk from 1916 until his retirement in 1963. He also had been mayor of Norwalk for 25 years. Surviving is his widow, Gertrude.

◈ **Vincent J Shippy, MD,** 88, Pulaski, died Mar 7, 1977 in Green Bay. Born Jan 30, 1889 in Plover, Wis, Doctor Shippy graduated from Marquette University School of Medicine in 1912. He had practiced medicine in Pulaski until 1972 when he retired.

Anthony J Pace, MD, 74, Eagle River, died Mar 9, 1977 in Eagle River. Born Sept 27, 1902 in Chicago, Ill, Doctor Pace graduated from Loyola University of Medicine, Chicago, Ill, in 1929. He served in the United States Air Force from 1942-1946. Surviving are his widow, Mary; two sons, Richard, Orlando, Fla, and Charles of Eagle River.

◈ **Joseph A Looze, MD,** 83, New Franken physician for 50 years, died Mar 23, 1977 in New Franken. Born July 23, 1893 in Kewaunee County, he graduated from Marquette University School of Medicine in 1925. Surviving is his widow, Ida.

◈ **John Robert Altmeyer, MD,** Milwaukee, died Apr 9, 1977 in Milwaukee. Born June 18, 1918 in Tarentum, Pa, Doctor Altmeyer graduated from the University of Pittsburgh Medical School in 1944. Surviving is a sister, Mrs Marie Kitzer, Arnold, Pa.

◈ **Wendell A Killins, MD,** 79, Green Bay physician for many years, died Apr 14, 1977 in Carmel, Calif. Born Oct 10, 1897, Doctor Killins graduated from the University of Nebraska School of Medicine in 1921. Surviving is a brother, Jack A Killins, MD of Green Bay. ■

The age of the CAT for Wisconsin physicians

Six wisconsin hospitals have already entered the age of whole body CAT or computerized axial tomographic scanning, and about 12 other hospitals are planning to purchase a scanner in the near future.

As a diagnostic tool, the CAT scanner has been hailed by many physicians as the greatest medical advance in 25 years. It combines the accuracy of sensitive x-ray detectors with the speed of a computer to produce detailed, high-resolution cross-sectional images.

The scanner has an arm which directs a pencil-thin x-ray beam through the patient's body as it rotates around the patient. The beam is directed at an angle perpendicular to an axis running from the patient's head to his feet. Different body structures affect the beam differently. Variations in beam intensity as it rotates are detected by sensors which relay the information to a computer. After the beam completes its cycle in 20 seconds, the computer constructs a black and white image from the tissue density variation of an anatomical cross-section about 13 mm thick. This picture can be observed on a television screen or be reproduced on film.

A CAT scanner's ability to detect density differences of 1% or less and resolve 3 mm structures should enhance a physician's ability to localize tumors, other abnormalities, and structures not found by other tests. For example, lesions should be detected and defined in sites such as the pancreas, lungs, retroperitoneum, adrenal glands, and pelvis. It should even be possible to locate metastases to retroperitoneal lymph nodes and the liver. Hopefully, this will permit earlier initiation of suitable therapy.

Axial tomography can delineate a tumor accurately in three dimensions in relation to surrounding normal structures. Information on the radiation absorption characteristics of the tumor and normal tissues through which a treatment beam would pass will correct the treatment plan for differences in tissue density and provide more accurate dose administration in each patient.

Knowledge of tumor size is extremely important in determining the appropriate margins of resection or irradiation in order to limit treatment volume without missing tumor tissue. Noninvasive staging of the extent of the disease is difficult in many anatomical areas. Certain organs and structures in the abdomen, retroperitoneum, and pelvis are not readily defined by standard radiographic approaches, but will be with whole body CAT scans.

To establish the role whole body computerized axial tomography may have on tumor diagnosis and control, CAT scan information must be correlated with other diagnostic procedures, such as physical examination, routine radiographic studies, isotope scans, angiography, lymphangiography, ultrasonography, laparotomy, and the like. If it proves reliable in defining the extent of disease and can identify nonresectable disease, some of these studies might be omitted. The dose of radiation necessary for a scan is acceptable for individuals in whom the results are needed to determine proper diagnosis and treatment but is too large for a mass screening program.

A new scanner has recently been installed at the University of Wisconsin Hospitals in Madison. A grant from the National Cancer Institute has been received by the Departments of Human Oncology and Radiology to help establish the role that whole body CAT scanning may have in tumor diagnosis and its accuracy in defining the extent of disease. The information obtained from this study will be made available to any physician who may have patients who could benefit from such scans. In order to conduct this evaluation, UW radiologists are interested in having physicians and surgeons in Wisconsin cooperate by sending their patients with known or possible thoracic, abdominal, retroperitoneal, or pelvic masses who are being considered for exploratory surgery for CAT scans before surgery.

A patient would not need to be admitted to UW Hospitals for a scan. The examination can be done rapidly on an outpatient basis, with minimal patient discomfort. Every effort will be made to obtain the scan promptly. Copies of the scans and the interpretations will be returned with the patient, so cooperating physicians will benefit immediately from information derived from the scans. Following surgery, UW physicians would like a complete description of operative findings in order to assess the method's accuracy and capabilities.

The cost will be paid by a grant from the National Cancer Institute, if the referring physician will carefully describe the operative findings. Cooperation of surgeons and other physicians in Wisconsin will allow their patients to benefit from this new diagnostic modality now and also make future use of CAT scanners by Wisconsin physicians more meaningful.

For further information or to schedule a CAT scan for a patient, please contact: George W Wirtanen, MD; A L Wiley, Jr, MD; or William L Caldwell, MD, Wisconsin Clinical Cancer Center, Departments of Human Oncology and Radiology, University of Wisconsin, 1300 University Avenue, Madison, Wisconsin 53706, phone: (608) 262-2474.

—Dorothy J Buchanan-Davidson, PhD
Science Writer
Wisconsin Clinical Cancer Center

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

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The *Wisconsin Medical Journal* gratefully acknowledges publication support of this BLUE BOOK issue through a contribution from the Crownhart Memorial Account of the State Medical Society's Charitable, Educational and Scientific Foundation.

Physician and Hospital Records: Retention and Inspection

A. Retention of Records

It is agreed that ownership of medical and hospital records rests, respectively, with the physician and the hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have, during the last two decades, declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because physicians, hospital personnel, patients and others are not always clear as to their respective rights and obligations and because there is uncertainty as to what constitutes a "medical record" or "hospital record", representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association jointly developed an *Interpretation* on this subject in 1959, which was reprinted in full in the June 1975 BLUE BOOK issue of the *Wisconsin Medical Journal.* (74 *WMJ* 30)

The *Interpretation* was approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association. It contains recommendations and suggestions regarding hospitals' and physicians' responsibilities under Section 269.57 (4), which was enacted as part of Chapter 301, Laws of Wisconsin, 1959. Subsection (4) in revised form has been renumbered 804.10 (4) Wisconsin Statutes, 1975, and became effective January 1, 1976. It is reprinted in the box on page 27 of this article.

It should be emphasized that parts of the *Interpretation* are no longer relevant because of intervening amendments to the 1959 statute. Its principal value was that it represented the joint thinking of the State Medical Society and the Wisconsin Hospital Association, acting through their respective governing bodies and officers. Where there is a difference between the wording of the *Interpretation* and this article, the article governs.

Patient and hospital records today include not only the written history, diagnosis, treatment, prognosis and related reports, but such additional items as: x-rays, laboratory reports and correspondence with other physicians relative to a particular patient and to a particular condition.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 18 who are mentally competent; (2) over 18 who are mentally ill; and (3) under 18.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an

aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not legal considerations.

2. A mentally normal patient of legal age has *3* years within which to sue *for personal injuries.* If a patient elects to sue on *a contract* rather than for alleged *negligence,* he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. There is no *legal* requirement for accommodating a former patient longer than the suggested 6 years, although where fraud is alleged, the injured party has 6 years in which to sue *after* discovery of the fraud. For example, a surgeon is chargeable with "fraud" who is aware he has left a foreign object in a patient's body but does not disclose that fact to the patient, or the latter's representative.

3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 18 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 18 and mentally ill at the time of his treatment or hospitalization, or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within one year of his recovery, and if he does not recover, within a maximum of 8 years after the alleged negligence.
   C. If the patient is a mentally normal minor at the time of the treatment or hospitalization, he must sue for the alleged negligence by the time he reaches 19, unless his guardian did so before the patient reached 18.
   D. If the patient was a minor and mentally ill at the time of the alleged negligence, and becomes mentally normal by age 18, he must sue for the alleged negligence by the time he is 19. If such patient remains mentally ill after reaching age 18, his guardian must start suit within 8 years of the alleged negligence, or before the patient is 19, whichever date occurs later.

4. To the extent that patients' records are retained to assist in collection of accounts, such claim must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

B. Inspection and Copying of Medical Records and Reports

Both the old and revised subsections limited the right to inspect and copy medical or hospital records and reports to situations where *no litigation* is pending respecting the medical care and treatment covered by the authorization. Once litigation is begun, situations involving the inspection or copying of medical records and reports are governed by other statutes. The revised text of the subsection, renumbered as 804.10 (4), which took effect January 1, 1976, is set out in the box on page 27 of this article.

A physician or hospital administrator, and anyone designated by either of them is urged to read this article *before* allowing the inspection or copying of medical records and reports which are in his custody.

An authorization from or on behalf of a patient allowing the designated person to inspect and copy medical or hospital records or reports concerning the patient's care and treatment may not specify what specific records are covered. The physician on the other hand may have records that go back many years and cover more than one treatment or series of treatments, and more than one illness or hospitalization, or more than one member of a family.

Before complying with the request of a patient to inspect and copy his records, the physician should confer, if practical, with the patient or his representative to ascertain *what* illness, *what* treatment, and *what* period of time are intended by the authorization. If by any chance the records or reports contain material relating to conditions which would be embarrassing to the patient or which might involve other members of the immediate family, the patient or a representative might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any such parties.

Some physicians are requesting not only that the time periods to be copied from a medical record or report be specified, but also that each particular illness be specified in the authorization from the patient.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member.

Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Following are some major considerations and safeguards to be observed by a custodian of medical records and reports:

1. Validity of Authorization

Upon being presented with an authorization form for the inspection or copying of medical records and reports, physicians or hospitals must assure themselves that (1) the patient in fact signed the authorization, (2) was of legal age, and (3) had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian. Where there is no formal guardianship of a minor, a parent may sign as the natural guardian except where the minor is emancipated as by marriage or self-support.

The physician or hospital must take such precautions as are necessary to satisfy themselves that those designated in the authorization are thereby empowered to inspect and copy the medical records or reports covered by the authorization.

The physician or hospital representatives must also be satisfied that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any reasonable doubt as to the identify of a person presenting authorization to inspect or copy records, the physician (or his representative) or the hospital (or his representative), depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the authenticity of the signature or the mental capacity or age of the patient.

The statute authorizes the personal representative, or the beneficiary of a life insurance policy, to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Domiciliary Letters" which are issued by the County Court, Probate Branch.

In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) the person signing the authorization is the beneficiary under the policy. The burden of proof is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized.

On being satisfied that the authorization presented is properly signed, as previously outlined, that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the physician or hospital to permit such person to inspect and copy "any medical or hospital records or reports concerning" the care or treatment designated in the authorization. Exactly *what* records and reports may be inspected and copied is discussed in point 2 immediately following.

2. What Can Be Inspected And Copied

It is first necessary to determine what must be made available for inspection and/or copying.

It is believed that under a fair interpretation of subsection (4) the physician's records and reports (office or hospital), and the hospital clinical record or chart should be made available for inspection or copying.

In the case of x-rays there seems to be some disagreement among legal authorities as to whether they are part of the medical record as such, or are technically

STATUTE

Former Section 269.57 (4) of the Wisconsin Statutes relating to the examination or inspection of medical records on patient authorization was revised and renumbered as of January 1, 1976, to read:

> "804.10 (4). Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

NOTES: The principal differences between the old and new statutes are:

1. The earlier statute permitted the inspection and copy on the written authorization of a patient or his representative of "any medical or hospital reports, photographs, records, papers and writings concerning [his] care or treatment."

The revised subsection imposes narrower requirements limited to "medical or hospital records or reports."

2. Former Section 269.57 (4) provided that a custodian of medical or hospital records who refused to comply with an authorization submitted by or on behalf of a patient was liable to such patient "for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs."

Section 804.10 (4) provides that such custodian "shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover." This is a much more sevcre penalty.

photographs. It is advised that x-rays *not* be released unless by court order, and that they be inspected *only* under proper supervision, in the case of a physician's office, by the physician in charge, an associate, or the designee of either, in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator.

X-rays must *not* be taken from the office of a physician or other custodian unless required by a court order or subpoena. When either of the latter is served on the custodian of medical records or reports, Section 804.10 (4) *is no longer applicable,* and the authorization is no longer in force.

One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional responsibility of the attending physician and of those acting under him, and may be described as the "official records and reports". The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record or report, other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her acts or observations made pursuant to special or standing orders, technically relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute. Nothing but one of the above should be furnished for inspection or copy.

Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, are not licensed to practice medicine, and are not necessarily recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic "records" relating to the care or treatment of the patient.

3. Safeguards

The following safeguards are recommended:

(a) Section 804.10(4) does *not* in words or by implication, give a right *to remove* any records from a physician's office, or hospital, the records being the legal property of the physician or hospital.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on *in the presence* of a custodian (hospital or physician), or the representative of either. The statute does *not* require a physician or hospital, to copy any records at the request of a patient or his representative. If a request is made by a patient or his representative, and the request is granted, the physician or hospital making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital records or reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

(b) Few people, other than medically trained personnel, know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

(c) The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but as soon as the convenience of a physician, an administrator, or a record librarian, *reasonably* permits, after taking into account the urgency of prior demands on their time and personnel and whether advance notice had been given of the demand of the particular patient.

(d) When there is any indication that legal proceedings may ensue, the physician or hospital served with a proper authorization to examine or copy a patient's records should promptly notify the insurance carrier of this fact, and also the attorney of the physician or hospital. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such authorization be given by the person receiving same to the other interested parties.

4. No Authorization Forms Suggested

Since no words appear in Section 804.10(4) prescribing the form of an authorization to inspect and copy a patient's medical or hospital records or reports concerning his care or treatment, model forms are not suggested. The observance of the precautions and safeguards emphasized earlier in this article should assure that the patient's interest is protected while at the same time protecting the professional or institutional provider of services.

As a final observation, although legal title to medical records and reports is in the physician or hospital, depending on their location, the general legal opinion is that such records and reports are held in the custody of the physician or hospital for the benefit of the patient. It is on that basis that they are made limitedly available to him or to persons designated by him. ■

BROCHURES AVAILABLE

- **SMS—An organization on the move!**—An "envelope stuffer" brochure which explains the Society's efforts in such areas as professional liability, political action, Medicaid, communications, continuing medical education, negotiations with third parties, benefits and services of SMS membership.
- **To Your Good Health**—An SMS "envelope stuffer" brochure which explains why medical costs have increased and how individuals can reduce medical bills by staying healthy.

INTERPROFESSIONAL CODE 1977

State Medical Society of Wisconsin / State Bar of Wisconsin

1. PREAMBLE

Members of the medical and legal professions recognize that physicians and attorneys are drawn into steadily increasing association as the knowledge and services of both professions are required so that rights of individuals may be appropriately determined before various tribunals.

It is deemed advantageous at this time to join in a common effort to develop a voluntary compact between physicians and attorneys to clarify and delineate the uncommon language and common problems; and to communicate to both the medical and legal professions through an interprofessional code, the manner in which each can best serve the public and assure it the best medical and legal services obtainable.

The code is a series of "ground rules" or procedures between physicians and attorneys. The code can be helpful to achieve a harmonious working arrangement between the two professions.

2. INTERPROFESSIONAL RELATIONSHIPS

The parties should understand that legal proceedings in this country are conducted under the "adversary system." The parties should also understand that medicine is not an exact science, that medical opinions may vary, and that there can be controversy over specific patient treatment. The attorney is thus an advocate for his client, and does not and cannot properly represent any person with an interest adverse to his client. This adversary system is based upon the thesis that usually justice can be best accomplished if the two or more contestants can present their points of view to a neutral third person or body who can weigh the opposing claims. The physician's role is to provide for the health and well-being of the patient. The attorney's role is to present his client's case as completely and effectively as possible, bearing in mind that as an officer of the court he has an obligation not to institute nor engage in frivolous or groundless litigation. The medical professional affirms the obligation of a patient's attending physician to cooperate with the patient's attorney in supplying both facts and professional opinions as to the nature and extent of the patient's illness, injury or disability, providing certain prerequisites have been met, as hereafter cited.

The physician should never advise either his patient or the attorney as to the amount of damages a patient should seek to recover, nor advise as to the trial techniques which should be followed to effect a recovery. This does not preclude the physician from advising the attorney as to future medical expenses. There should be cooperation between the physician and the attorney, each assuming his proper responsibility for the benefit of the patient-client.

3. MEDICAL EXAMINATIONS

A. General

1. The law provides that a party to a lawsuit may be required by the opposing party to undergo a medical examination by agreement of the attorneys or under a court order.

2. When an appointment is made by either party for the medical examination of a person, the attorney for the party to be examined should be given explicit instructions to such party that the physician must be notified in ample time should it become impossible for the party to keep the appointment, otherwise the physician is justified in making a charge for such canceled time.

B. Scope of Examination

1. The examination may be limited by the agreement of the attorneys or the court order, provided sufficient information is obtainable to reach an opinion. The attorney for the party to be examined has the responsibility of notifying the physician of any such limitation.

2. Subject to the above limitation, the physician may take a history and perform such examinations as may be advisable in his judgment to formulate an opinion regarding the nature and extent of the party's medical condition.

C. Presence of Attorney

On occasion and subject to approval of the court, a party being examined may have his attorney present during the examination.

4. WRITTEN MEDICAL REPORTS

A. The Attorney

Attorney requests for reports from a physician shall be made in writing. It is the initial responsibility of the attorney to pay the physician for his time in preparing the reports and for all other services requested by the attorney.

It is understood that only a reproduction charge will be made for copies of reports already in existence.

B. The Physician

1. The physician has control of his patient's laboratory data and medical records but this does not preclude the delivery of copies to another physician, provided the permission of the patient is obtained.

2. Requests for medical reports should be submitted timely and honored promptly. Undue delays in providing medical reports or bills bearing on a patient's legal rights may prejudice his case.

3. If a physician is unable to make a complete medical examination within the time required, he should notify the attorney. In this event, a preliminary report clearly designated as such, may serve the attorney's needs until a complete evaluation can be rendered.

4. Patient's Authorization

   a. The physician shall have, and the attorney shall secure, the patient's written authorization before releasing any report, test or other information concerning a patient.
   b. Where a physician has been retained by the attorney or an insurance company, such authorization is not necessary, nor legally required, in order to send a report or a test result to an attorney or insurance company.
   c. In Worker's Compensation matters no authorization is required.

5. Content of Report—The following, where applicable, are necessary for complete presentation of a case and should be included in the report:

   a. Date, time and place of first visit.
   b. The history of the injury or medical condition including preexisting disease or injury.
   c. Nature of examination and findings.
   d. Results of laboratory work, x-rays and consultations.
   e. Opinion including, where possible, diagnosis and prognosis. The opinion should evaluate future disability, the necessity for future treatment or surgery, if any, the effect or aggravation of any preexisting disease or injury, and projected convalescence.

   In addition, where the report is made by a treating physician with respect to a patient's condition:
   f. State the patient's present condition.
   g. Enclose separately an itemized statement of charges for actual medical services rendered to date. Charges for medical reports and attorney consultations should be submitted separately.
   h. Include estimate of cost of future medical care, where appropriate.
   i. Omit any reference to insurance or other compensation.

5. DEPOSITIONS

A. Physician-Patient Privilege

1. In a personal injury suit, the law states that the usual obligation of confidence in the physician-patient relationship is waived where testimony is given, or documents produced, under court order, subpoena, or agreement.

2. As evidence of the above waiver, the patient may file with the physician or his record custodian an appropriate form.

B. Deposition Defined

A deposition is an official proceeding authorized by law whereby a person, such as a physician, patient or client, may be required to give testimony and be cross-examined under oath outside of court before a court reporter and in the presence of attorneys representing the parties. The deposition may be recorded on videotape. He may be required to produce all medical records at the deposition hearing. He may also be required to release the records or reproductions thereof to the court reporter.

C. Time and Place

The time and place of the deposition should be set by the attorney through mutual agreement with the physician.

D. Subpoenas

If the deposition of a physician cannot be set by agreement, the physician's attendance can be required by subpoena. If any doubt arises as to the effect of the subpoena, the physician should promptly consult the attorney subpoenaing him, his own attorney, or the court.

E. If Attendance at Deposition is a Hardship

If the time and place described in the subpoena for the deposition hearing creates a hardship, the physician should immediately bring this fact to the attention of the attorney for his patient, the attorney causing the subpoena to be served, his own attorney, or the person before whom the deposition is scheduled.

F. Deposition Fees

Since the physician whose deposition is to be taken may be called upon to give expert testimony, he is entitled by law to charge the party requesting the deposition a reasonable fee for his deposition. It is urged that the attorney discuss this charge, and the responsibility for its payment with the physician before the deposition is taken.

6. SUBPOENA OF MEDICAL RECORDS

A. Subpoena of Medical Records for Deposition or Trial

1. Physicians should be aware that the patient, in bringing a legal action, has waived confidentiality for all medical information which relates to the litigation.

2. The physician or his custodian of records may be subpoenaed to produce all medical records relating to the litigation. In such cases the physician or his custodian of records shall take the records to the deposition or trial unless other satisfactory arrange-

ments are made for reproduction of the original records.

7. RELATIONSHIP OF PHYSICIAN AND ATTORNEY PRIOR TO TRIAL

When a physician has consulted with or has agreed to testify for one of the parties in a case and is approached by attorneys or other representatives of parties with adverse interests, he shall advise them of his prior consultation or commitment.

A. Conferences Between Physician and Attorney

The physician and attorney should confer prior to trial or deposition hearing.

8. THE PHYSICIAN AND THE TRIAL

A. Subpoena for Trial

Most attorneys will not subpoena a physician they expect to call as a witness, preferring to make personal arrangements with the physician, relying upon his assurance to appear. Some attorneys subpoena medical witnesses because it may be essential in order to secure a continuance if for some reason the physician fails to appear as required.

B. Recommended Policy Regarding Subpoenas and Physician's Appearance

1. An attorney shall notify a physician reasonably in advance of the service of a subpoena, unless it would be detrimental to his client's interest to do so.

2. The attorney shall make every effort to arrange in advance with the physician the time the physician will be called to testify.

3. Recognizing the time problems of the medical profession, attorneys shall make every effort to avoid unnecessary delays for the physician; however, the process of law and the time of other individuals must also be recognized and respected by the physician.

C. Duty to Testify

Our system of justice depends upon being able to require any citizen's attendance at a judicial proceeding and to give testimony regarding the case. It is the physician's legal duty to respond to a subpoena as any other citizen, except where grave emergency prevents his doing so. The physician assumes the risk of convincing the court that the emergency was of sufficient gravity to justify his ignoring the subpoena.

D. The Physician as a Witness

1. All witnesses should testify objectively. It is the duty of an expert witness to render his opinion without regard to whether it will be favorable to one party or the other, nor with how it will affect the final result of the lawsuit.

2. Treating Physician as a Witness—Any person who has knowledge of facts on a relevant issue may be called upon to testify as to these facts. A physician who has acquired knowledge of a patient or of any specific factor in connection with a patient may be called upon to testify as to those facts without any compensation other than the regular statutory fee which all witnesses are entitled to when they appear in court.

3. Non-Treating Physician as a Witness—A physician who is not a party to a legal action and who is requested to testify is entitled to receive reasonable compensation. Such fees shall be paid by the party requesting him to attend.

E. Choice of Language by Medical Witnesses

The physician should use non-technical language wherever possible. He should bear in mind that his testimony is addressed to laymen. If it does not explain and clarify, it has not achieved its purpose. Technical expressions should be followed with simplified explanations or illustrations.

F. The Physician on the Witness Stand

It is proper for opposing counsel to cross-examine the physician with respect to his qualifications, fees, memory, records, diagnosis, prognosis and other opinions, as well as any other facts bearing on the weight and credibility of his testimony. The witness may be assured that if an attorney examining him exceeds the bounds of propriety, the court or the attorney for whom the physician is testifying should intervene.

9. COURTESY TOWARD PHYSICIAN

The lawyer should treat the physician on the stand with courtesy and tact; however, the physician should realize that under the "adversary system" it is permissible and not unusual that other than a completely objective attitude may be used by attorneys toward the testimony being elicited from the physician.

A. The Province of the Objection

Trials are governed by the rules of evidence. When an attorney makes an objection to a question, the physician should not answer until the court has made a ruling on the objection.

B. Categorical Answers

When a physician feels that "yes" or "no" will not accurately answer a question, he should so state. Permission will usually be given to qualify or explain the answer.

C. Opinions May Differ

Some physicians are reluctant to express opinions based upon their own knowledge, experience and observations because other physicians have expressed different conclusions. This reluctance is not well grounded and should be disregarded. Of course if new facts or other opinions are brought to the physician's attention which cause him to modify his opinions, he should not hesitate to express himself accordingly.

D. Hypothetical Questions

1. It may be necessary to use hypothetical questions in eliciting testimony from expert witnesses. These questions can be very troublesome and confusing unless proper care is taken to insure that all elements of the questions are clearly expressed and are not ambiguous. They must also properly reflect the testimony which has been submitted or which the attorney expects to submit in support of his contentions. It is, therefore, recommended that wherever feasible, the attorney should pose his questions to the physicians in advance, and in writing, so as to eliminate any misunderstanding that might arise.

2. The expert witness in answering the question must make certain that he understands all of its elements and that it is complete enough so that he can properly express an opinion.

3. The answer to the hypothetical question must be based exclusively on the facts stated in the hypothetical question.

10. COMPENSATION TO PHYSICIAN

A. Physician's Charges for Services Provided to Attorney

1. It is strongly recommended that the physician and attorney arrive at a mutually agreeable fee for each service requested by the attorney prior to providing the service, and the responsibility for payment.

2. The attorney is responsible for payment of services which he requests and which are directly connected with preparing his client's case for trial or for settlement. These services will include, but are not limited to, the following:
   a. Examination and preparation of written reports requested by the attorney.
   b. Conferences with the attorney.
   c. Research.
   d. Record review and appearance for depositions.
   e. Court or administrative appearances.

3. As a matter of policy, an attorney is not to request a physician to testify as an expert without making arrangements for reasonable compensation.

4. The physician is obligated to cooperate with the attorney in the presentation of testimony and the attorney is obligated to cooperate with the physician in arranging in advance for a time certain for such testimony. The attorney should not make use of a subpoena unless the physician is uncooperative or unless prior arrangements have been made.

5. When there is disagreement as to the fee or service involved, both parties shall resolve the dispute by submission of the matter to the Arbitration Committee established by this code.

6. Under no circumstances may a physician charge a fee for an examination or for testifying which is dependent upon the outcome of the litigation.

B. Payment of Physician's Charges for Treatment; Attorney's Role

1. The patient is directly responsible for the physician's charges for treatment, even though the patient's injuries may be the subject of litigation. The attorney shall make such responsibility known to his client.

2. There are occasions in which the patient cannot settle all of the physician's charges for services as they are incurred. If at the conclusion of a case such instance exists, the attorney owes the professional courtesy to the physician to see that the physician's reasonable charges are paid to the extent of the net proceeds.

11. MEDICAL-LEGAL INTERPROFESSIONAL COMMITTEE

A. Composition

This committee shall be composed of at least three members of each profession.

B. Disputes—Arbitration

Any interpretations of, or dispute arising under, any provision of this code shall be submitted to the Interprofessional Committee for binding arbitration in accordance with procedures established by the committee. ■

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

Until recently, only licensed physicians or registered pharmacists could lawfully offer to sell or sell contraceptive articles.

Under an opinion of the Attorney General, dated May 16, 1977, interpreting Section 450.11(5), enacted in 1976, professional nurses registered under Section 441.06, Wis. Statutes, 1975, may offer to sell or sell any contraceptive article, including an oral contraceptive drug, provided the latter has been prescribed by a physician and that the article offered for sale or sold has been prepared for delivery. Such drugs include birth control pills.

Except for sales to physicians and surgeons licensed under Sec. 448.06(1), Wis. Stats., no person may exhibit, display, advertise, offer for sale, or sell any drug, medicine, mixture, preparation, instrument, article or device of any nature used or intended or represented to be used to produce a miscarriage.

Any violation of the above statutes subjects the violator to a fine of One Hundred to Five Hundred Dollars, or imprisonment not to exceed six months, or both.

References: Section 450.11, Wisconsin Statutes, 1975, and Opinion of the Attorney General, May 16, 1977.

MUST A
Wisconsin Physician Report?

1. Deaths?

The Wisconsin Statutes requires that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:

a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
b. All homicides.
c. All suicides.
d. All deaths following an abortion.
e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there was no physician in attendance within 30 days preceding death.
h. When a physician refuses to sign the death certificate.

Violations of the above are punishable by fine or imprisonment.

2. Treatment of automobile accident injuries?

No, unless there is a death.

3. Drowning?

Yes.

4. Gun shot wounds?

No, except where death results.

5. Hunting accidents?

No, except where death results.

6. Industrial accidents?

No, except where death results.

7. Industrial diseases?

Yes, to the Division of Health, Department of Health and Social Services, for diseases as required by statute or regulation.

8. Suicide attempts?

No; only death by suicide is reportable.

9. Sending of corpses to undertaker?

Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. Live births?

Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful. Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Division of Health, Department of Health and Social Services.

11. Communicable diseases?

Yes, to local health authorities, except for polio which must be reported locally and to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

12. Venereal diseases?

Yes, to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

13. Cancer?

Yes, to the Department of Health and Social Services.

14. Tuberculosis?

Yes, to your local Board of Health.

15. Chronic alcoholics?

No, even if you know or believe it probable that they are driving automobiles.

16. Epileptics?

No. But see article on page 68 of the June 1974 Blue Book issue.

17. Drug addiction?

No.

18. Abused children?

Yes. See article in January 1970 "Blue Book" issue of Wisconsin Medical Journal at page 25. A physician is subject to penalty if he does not report.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The law prohibits a physician from disclosing, except as specifically required or authorized by law, any information which he acquired in attending a patient and which is necessary for him to treat that patient. Information provided to the Division of Health which relates to personal facts about a patient may be used only for statistical or summary purposes or anonymously except as its disclosure may be necessary to provide services for the patient.

THE WISCONSIN POISON CONTROL PROGRAM NETWORK . . . .

. . . is approved and coordinated by the Division of Health, Wisconsin Department of Health and Social Services. It is a health service that provides standardized poison management information and treatment to both medical professionals and the general public through a network of regional and satellite centers.

Each center is staffed by specially trained poison information professionals available to answer telephone inquiries 24 hours a day, seven days a week.

Telecopying equipment enables the staff to make immediate contact with national headquarters in Pittsburgh when additional information or research is needed on difficult cases of ingestion.

The centers:

- recommend treatment procedures to physicians and to the public in poison emergencies.
- maintain a record of calls received, treatment advised or given and disposition of the case.
- report regularly to the Division of Health.

The two regional centers are:

Milwaukee Poison Center
Milwaukee Children's Hospital
1700 W Wisconsin Avenue
Milwaukee, WI 53233
Tel 414/344-7100

Poison Center — Madison Area
University Hospitals
1300 University Avenue
Madison, WI 53706
Tel 608/262-3702

The two satellite centers are:

Eau Claire Poison Center
Luther Hospital
310 Chestnut Street
Eau Claire, WI 54701
Tel 715/835-1515

Green Bay Poison Center
St Vincent Hospital
P O Box 1221
Green Bay, WI 54305
Tel 414/432-8621

In addition, other small poison control centers in many other hospitals may have direct contact with a regional or satellite center to receive assistance as a "member center" of the network.

This information provided by the
WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH
PO Box 309 Madison, Wis 53701

Brief Summary

E.E.S.400 FILMTAB®
(ERYTHROMYCIN ETHYLSUCCINATE TABLETS, ABBOTT)

Indications:

Streptococcus pyogenes (Group A beta hemolytic streptococcus)—Upper and lower respiratory tract infections, skin, and soft tissue infections of mild to moderate severity, where oral medication is preferred. Therapy should be continued for 10 days.

Alpha-hemolytic streptococci (viridans group)—Short-term prophylaxis of bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin.

S. aureus—Acute infections of skin and soft tissue of mild to moderate severity. Resistant organisms may emerge during treatment.

S. pneumoniae (D. pneumoniae)—Upper and lower respiratory tract infections of mild to moderate degree.

M. pneumoniae — For respiratory infections due to this organism.

Hemophilus influenzae: For upper respiratory tract infections of mild to moderate severity when used concomitantly with adequate doses of sulfonamides. Not all strains of this organism are susceptible at the erythromycin concentrations ordinarily achieved (see appropriate sulfonamide labeling for prescribing information).

Treponema pallidum—As an alternate treatment in patients allergic to penicillin.

C. diphtheriae and C. minutissimum—As an adjunct to antitoxin. In the treatment of erythrasma.

Entamoeba histolytica—In the treatment of intestinal amebiasis.

L. monocytogenes—Infections due to this organism.

Establish susceptibility of pathogens to erythromycin, particularly when *S. aureus* is isolated.

Contraindications:
Known hypersensitivity to erythromycin.

Warnings:
Safety for use in pregnancy has not been established.

Precautions:
Exercise caution in administering to patients with impaired hepatic function. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. Surgical procedures should be performed when indicated.

Adverse Reactions:
Dose-related abdominal cramping and discomfort. Nausea, vomiting, and diarrhea infrequently occur. Mild allergic reactions such as urticaria and other skin rashes may occur. Serious allergic reactions, including anaphylaxis, have been reported.

7033187

Communications Guide for Wisconsin Hospitals and Physicians

Purpose: This document establishes a communications guide for Wisconsin hospitals and physicians to promote cooperation between the allied medical professions and those who report medical news.

State Medical Society Statement: It is mutually agreed that the primary interest and consideration of the physician and the hospital are the care and welfare of the patient. It also is agreed that newspapers, radio and television exist for the common good and function to bring matters of general interest to the public quickly and correctly; and, therefore, the final decision of what is news remains with news personnel. This guide recognizes the limitations and obligations of the health care and media professions while striving to establish an atmosphere of mutual trust and harmony.

Hospital Association Statement: Although the nature of hospital services is private and quite personal, hospitals have the responsibility to account for their public trust through open and candid communications. This responsibility rests with the hospital board of trustees which usually delegates it to the hospital administration.

All significant events at a community hospital should be available to the public. Any limitations on this flow of information are based with the patient, whose total health care is paramount and the hospital's very reason for being.

As a communications guide, this document is not intended to supersede established local custom, but it is designed to guide hospitals in formulating their own communications policies which should be made known throughout the hospital and to all appropriate hospital personnel.

A Joint Service Publication of

STATE MEDICAL SOCIETY OF WISCONSIN
WISCONSIN HOSPITAL ASSOCIATION

Approved by the Council of the State Medical Society of Wisconsin and the Board of Trustees of the Wisconsin Hospital Association

JUNE 1977

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PATIENT MEDICAL INFORMATION

Medical information is private and confidential.

Medical records pertaining to the care of a patient may not be revealed to a third party without the patient's consent. Original medical records may be removed from a hospital or physician's office only under subpoena. A medical record may be inspected or copied only with the written authorization of the patient.

INTERVIEWS AND PHOTOGRAPHS

Requests from the news media for patient interviews will be granted only with the patient's permission. The attending physician or responsible medical or treatment supervisor must be consulted to insure that the patient's condition or interest will not be jeopardized. When the patient is a minor, prior written consent from the parents or guardian must be obtained.

Access to the news media is a prerogative of the patient. However, a hospital or physician in charge can decline, when the patient's condition does not permit him to be disturbed or during crisis situations which impede the delivery of medical services, to grant permission for an interview and/or photograph even when consent is granted by the patient or his immediate family. Such denials are often temporary in nature; and when circumstances permit, the hospital spokesperson can seek clearance.

For each specific request for photographs or interviews, the hospital should require for its records and protection, a written patient consent form. This form should be completed, dated and signed prior to such photographs or interviews. This consent form should be filed, and should become a part of the patient's permanent medical record.

Photographs have strong reader and viewer appeal, and may be legitimately used in good taste. In addition to the patient and physician consent procedures outlined above, certain extraordinary situations may arise on occasion. These include:

(1) Photographs by police photographers may be taken without the patient's consent and without the physician or hospital incurring liability. However, as always, the physician or hospital must reserve the right to refuse consent under certain circumstances, when, in his/her judgment, the presence of police photographers or officers might worsen the patient's condition, or for other reasons, when common sense dictates some discretionary action.

(2) In all other cases, the written consent of the patient is necessary before pictures may be taken. This includes non-news photographs or film, such as surgical or scientific motion pictures or photographs.

(3) Deceased or unconscious patients may not be photographed, except in police cases.

(4) Patients with severe burns or facial injuries or other serious disfigurement generally will not be photographed, even though permission is obtained. Good taste should govern any exceptions.

A hospital representative should stay with the patient throughout the entire session with the media. It is recommended that a member of the nursing staff also be available to watch the patient for signs of pain or exhaustion and to assist with the interview or photography session as needed.

HOSPITAL AND PHYSICIAN RELATIONSHIPS WITH THE NEWS MEDIA

Each hospital should have available at all times an authorized spokesperson to answer inquiries from the news media. The names of these designated persons, with telephone numbers and hours of availability, should be made known to telephone operators, admitting personnel, the information desk, nursing supervisors and nursing units, emergency rooms and other hospital personnel likely to receive calls from the news media. These names also should be made available to all news and information agencies in the community or service area.

Information requested, when dully authorized, should be provided to the media as rapidly as possible within the framework outlined in this document. Although reporters judge what is news, the hospital, the physician, and the patient when appropriate, as a team, are the competent judges of what serves the patient's best interest. Their responsibility is to weigh the physical, mental and emotional effects on the patient of the information-gathering activities of the media representatives.

Media representatives on assignment may be required to show proof of identity on demand by hospital officials. This is to protect all agencies and persons from misrepresentation.

DEADLINES

Deadlines are an essential daily routine of the news media. Therefore, it is crucial that the information requested be given immediately. However, if the information is not available at the time of request, the physician or hospital spokesperson should promise to relay the information as soon as possible. The media realizes there are times when the information must be delayed to insure accuracy. Should the information not be available immediately, hospital personnel or the physician should promise the media representative a return telephone call when the information becomes available. If information is promised by a certain time, and unavoidable delays are encountered, the media should be so advised.

EXCLUSIVES (MEDIA GENERATED)

If a news reporter develops an exclusive story through his/her own initiative, the right of the exclusive should be respected. There should be no initiative made by a physician or hospital to give the story to another news representative. Protection of an exclusive story ends at the moment the story is first printed or broadcast. However, if an independent approach is made by another reporter about the same subject, there is an obligation to release the information.

NOTE: When used in a communications sense in this guide, the term "hospital" refers to the person(s) authorized by the institution to be its spokesperson(s).

Reprints of this guide are available upon request to the Communications Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701; phone 608/257-6781.

EXCLUSIVES (HOSPITAL OR PHYSICIAN GENERATED)

The right of all media to authorized equal access to the news is sometimes qualified in cases of specific stories which may be used more appropriately by a single media outlet. This situation often arises with a feature or "human interest" story. To awaken interest in the media for a particular story, the hospital or physician may wish to design it for the needs of one news outlet, perhaps a news outlet which has shown particular interest in a subject or topic. However, if this is done, the hospital or physician should make sure that over a period of time, all media interests are allowed to share the exclusives equally.

RESTRICTED AREAS

Hospitals are bound by certain regulations and policies which limit access to certain areas or departments in the hospital facility. This may apply particularly to the emergency and maternity departments, operating rooms and special care units. Requests by the media which may seem to be in conflict with regulations or ordinances, must first be cleared with the hospital administration or the attending physician, when appropriate.

The hospital emergency department is an example of a treatment area, access to which is usually limited to persons engaged in their care. Unless so authorized, emergency department personnel should not be permitted to release information on patients to the media. If reporters want to speak to persons being treated in the emergency area, they must contact the hospital's official spokesperson, who will attempt to make any arrangements deemed appropriate and obtain the patient's and physician's permission.

RELEASE OF INFORMATION

It is in the best interest of the general public and the hospital that the hospital provide accurate information to the news media. Each hospital should be consistent, fair, and timely in its release of information. Therefore, a policy should be established and made known within the hospital to define the way in which information shall be released. If patient information is to be released, the following may be used as a guideline:

1. Name, address, occupation, sex, age, marital status.
2. Condition of patient. Standard definitions of patient condition are suggested within a community in order to avoid confusion or misunderstanding. Examples of patient information are:

   A. TREATED AND RELEASED

   B. GOOD—Vital signs are stable and within normal limits. Patient is conscious and comfortable.

   C. FAIR—Vital signs are stable and within normal limits. Patient is conscious and may be uncomfortable.

   D. SERIOUS—Vital signs are unstable and not within normal limits. Patient is acutely ill.

   E. CRITICAL—Vital signs are unstable and not within normal limits. Patient is critically ill and may be unconscious.

Any release of information regarding the condition of a patient should not be made unless the immediate family has been notified previously of the condition. As a general rule, the prognosis of a case should not be released. If, however, in the judgment of the hospital and the physician such information should be released (as in the case of a noteworthy person), extreme caution should be used and will not be given unless appropriate consent is given by the patient or his family.

NON-POLICE OR NON-ACCIDENT CASES

Information permitted in items 1 and 2 above may be given. A statement consistent with "Nature of Accident or Injury," (see below) may also be given. The patient's physician must be consulted if there is any question as to the propriety of the release of information. In all cases, the patient, or if unconscious, the closest relative and physician, should be consulted about the release of information.

CASES OF PUBLIC RECORD

Patients brought to a hospital by a public conveyance and cases which are by law reportable to public authorities are cases of public record. Requests for details other than the routine information allowable in items 1 and 2 and the following paragraph on "Nature of Accident or Injury" must be referred to the proper public authority. The hospital cannot pledge that all information is accurate, since accident victims frequently are admitted in haste, and information immediately available may be incomplete. The hospitals should never attempt to describe the event that caused the injury. This must come from the police officer investigating the accident.

NEWSWORTHY PERSONS

When a person well-known to the community by virtue of public office or other circumstances becomes ill or is injured, it may become a matter of intense community interest. Every effort should be made to impress this fact upon the patient and to secure permission to release information. It is recognized that while hospitalization is basically a private matter, persons who are in the news, have to some extent, surrendered the right of privacy. When such a case is of serious public concern, the physician, in conjunction with the hospital administration, may arrange to issue daily or regular briefings on the patient's condition. The prominent person may have a spokesperson to whom all requests for information be directed. Should this be the case, the hospital spokesperson should cooperate.

NATURE OF ACCIDENT OR INJURY

BURNS—A statement may be made that the patient is burned, but the severity and degree of burns must be determined after treatment by a physician, and this information must come from a physician.

DRUG RELATED EMERGENCIES—In accordance with federal confidentiality regulations, no statement may be made that a patient is a suspected or confirmed drug user or alcoholic. No statement may be made that the admission was related to drug use or chemical dependence. All inquiries should be directed to the police department or the medical examiner.

FRACTURES—A fracture must not be described in any way except to state the member involved.

HEAD INJURIES—A simple statement may be made that injuries are of the head. It is not to be stated that the skull is fractured until definitely determined by a physician.

INTERNAL INJURIES—State location only, such as chest and/or abdomen and condition of patient. No statement may be made as to the organ involved.

INTOXICATION—No statement may be made as to whether the patient is intoxicated.

POISONING—No statement may be made concerning either motivation or circumstances surrounding a patient's poisoning or substance used. A simple statement may be made that the patient is poisoned and present condition.

SEXUAL ASSAULT—No statement may be made concerning the nature of the incident or injuries. The condition of the patient may be given.

SHOOTING OR STABBING—The number of wounds and their location may be stated if definitely determined by a physician. No statement may be made as to how the shooting or stabbing occurred.

SUICIDE OR ATTEMPTED SUICIDE—No statement may be made that there was a suicide or attempted suicide.

UNCONSCIOUSNESS—If a patient is unconscious when brought to the hospital, a statement of that fact may be made.

IDENTIFICATION OF PHYSICIANS

Upon request from the news media and only with the physician's consent, the hospital may give news media representatives the name of the attending physician.

ONGOING INTEREST

Interest in some patients may continue after the initial release of information following hospitalization. The hospital does not assume the responsibility for following the daily progress of these patients and issuing daily reports. If the media desires daily reports, they must request them as needed.

AFTER DISCHARGE

After any patient's discharge, the hospital is no longer in a position to disclose information to media concerning that person. All inquiries should be directed to the former patient or family.

BIRTHS

The birth of a baby is public record. Wishes of the parents should be taken into consideration when releasing information on the baby's name and other details. Local rules vary concerning photographs of infants. Hospitals must obtain written consent from parents before permitting photographs or television news film to be taken. News film or photographs usually are taken through the glass of the nursery; however, with the permission of the physician, hospital and parents, other arrangements may be made. In all cases, primary consideration should be given to the welfare of the infant.

The hospital should not release information relating to out-of-wedlock births of a general rule, except as required by law or court process. Specific patient requests to release this information should be handled on a case-by-case basis after obtaining written consent.

DEATHS

The death of a patient is assumed to be a matter of public record. Announcement of a death is not routinely made by a hospital. However, news of the death of a patient is public information *after* the family has been notified. Information about the cause of death must come from the patient's physician.

If a death becomes the object of a coroner's or medical examiner's investigation, inquiries as to the cause or circumstances of the death should be directed to the appropriate office. In instances other than police or coroner's cases, release of information may be made after a positive attempt to notify the family has failed and a reasonable period of time has passed.

The name of the funeral home receiving the body may be released.

MAJOR DISASTERS

Emergencies within the hospital should be communicated to the news media quickly and frankly. The hospital disaster and civil disturbance policies should contain specific provisions for swift cooperation with the news media.

PSYCHIATRIC ADMISSIONS

Patients admitted to a neuro-psychiatric unit of a general hospital are to be regarded as any other patient. No statement should be made concerning the patient's treatment nor should the name of the attending physician be released in this type of hospitalization.

ACTIVITIES OF FACILITIES AND PHYSICIANS

Growth, improvement and problems of community health organizations are important to service area residents and the hospital has the responsibility to keep the community informed on these matters. Wisconsin hospitals invest millions of community dollars annually in equipment and programs. These investments should be reported in the interest of accountability.

The full benefit of community health services cannot be realized without thorough consumer education. Adequate utilization of services and programs also depend upon a high level of consumer awareness. New health services and health programs should be publicized in the interest of consumer health education.

Hospitals should strive to keep the public informed in a factual and timely manner. The means employed by the hospital may include press releases, conferences, announcements and published reports. Purchase of time or space for communications is acceptable. Whether the hospital provides news or actually purchases time or space, the principle of accuracy must apply.

Physicians must make every effort to make certain that any activities do not solicit or attempt to solicit patients, directly, indirectly, or by agents. This is consistent with medical ethics and the law.

COMMUNITY HEALTH EDUCATION

Educational efforts involving health or medicine may be distinguished from what is regarded as "news" in the strict sense, and this requires special comment. Health education may require use of columns, or special articles in newspapers, newsletters, magazines, or live or prerecorded radio, television or film productions.

Hospitals and physicians have an obligation in the area of community health education. This is defined as separate from patient education which must be provided by health care professionals.

It is important that all partners in the health care process collaborate in educating and informing the public. Such collaboration recognizes the responsibility of both physicians and hospitals to inform and educate the public. While physicians, hospitals and other health care organizations may be involved in various types of health information and education, it is recognized that only physicians can diagnose and treat the patient.

It is paramount that information of a medical nature be accurate and have the approval of the appropriate physicians.

INTERNAL PUBLICATIONS

Effective internal communications programs are vital to hospital administration. Internal publications serve to inform and educate employees and other internal interest groups of hospital developments, plans and problems. The publications should be written in such a manner as to encourage employee pride in the hospital and offer both individual and team recognition in providing quality patient care. Such publications often express the philosophy of the hospital's approach to health care in addition to specific news and feature stories. Since copies of such publications often become available to those outside the hospital, the standards of accuracy and requirements for consent apply.

EXTERNAL PUBLICATIONS

SPECIAL PUBLICATIONS—Hospitals sometimes publish a monthly or quarterly magazine or pamphlet aimed at a special public, *ie,* the auxiliary, board members, and friends of the hospital. It is common to include such items as new hospital services, explanations of standard services or departments and human interest features. The writing should be clear, concise and informative, and avoid overt comparisons with other health care facilities or services.

ANNUAL REPORTS—An annual report provides an opportunity to account to the people a hospital serves. Annual reports should present a complete picture of the hospital's financial, operational and developmental condition. The community should be made aware of hospital problems as well as its successes. As with all other hospital communications, the rule of accuracy and appropriate consent apply.

RESEARCH AND SCIENTIFIC NEWS

News originating from the hospital's official spokesperson on medical advances, new techniques, or findings of medical research must come from an authoritative medical source. Hospitals are obliged to obtain the consent of the physician or patient concerned for the release of their names and information in connection with research and scientific news. The determination of whether the use of the physician's name would be ethical is the physician's responsibility, not the hospital's.

Photographs of speakers who appear before recognized medical groups, either in an official program or scientific meeting, may be permitted with the speaker's consent. The use of photos in connection with the election of physicians to medical staff positions—rather than in relation to the care of a patient—are generally permitted. A review of county medical society's policy should clarify this point.

DEVELOPMENT

Many hospitals are engaged in development or fund raising activities as a means toward financial stability. Philanthropy also fills an essential role in institutional growth, whether it be providing new services or acquiring new equipment or buildings. While development and public relations messages utilize the same medium of communication, their purposes are quite different. Nevertheless, principles of accuracy, honesty, and proper consent apply to all development communications. ■

Guidelines for Implementation of Joint Practice of Physicians and Nurses

Prepared by Joint Practice Committee of the State Medical Society of Wisconsin and Wisconsin Nurses Association. Approved by the Council of the State Medical Society of Wisconsin, March 5, 1977.

What is joint practice?

Nurses and physicians practicing together within the framework of their respective practice acts and other guidelines (such as joint practice statements issued by their professional organizations) who modify and develop their practice relationships and patterns to make each other's competence and contribution to health care more effective. The services provided to clients are complementary but not interchangeable either in responsibility or accountability. The collaboration includes both independent and cooperative decision-making and is based on the preparation and ability of each practitioner. The nurse may be in a satellite location, consulting with the physician in accord with mutually developed care protocols. A complete definition of joint practice would involve all health professions, the entire health delivery system, and even the concept of health.

The mere fact of working together does not necessarily constitute joint practice since the physician and nurse may not be practicing in a collaborative, collegial way.

What is a joint practice statement?

A joint practice statement embodies guiding principles and professional opinion on elements of joint practice by physicians and registered nurses in any setting. The authority of the Statement testifies to mutually agreed upon principles of practice. The Statement can be used to validate generally acceptable practices or patterns of care and to respond effectively and responsibly to new needs and methods of providing care.[1]

The Joint Practice Committee of the State Medical Society of Wisconsin and the Wisconsin Nurses Association developed a Joint Practice Statement in 1974 to assist physicians and nurses. The Statement accompanies these guidelines (see adjacent box). The Statement was approved by the House of Delegates of the State Medical Society and Wisconsin Nurses Association and formally endorsed by the State of Wisconsin Board of Nursing. The Medical Examining Board has officially recognized the need for the development of joint practice arrangements in accord with the principles enumerated in the Statement.

In addition to joint practice committees at the state level, the National Joint Practice Commission, composed of eight members each from the American Medical Association and the American Nurses Association, facilitates joint practice efforts nationally.

How are local joint practice committees established?

In each health care delivery setting involving the practice of registered nurses and physicians, it is advantageous to have them affiliate in joint practice committees to provide both with an organizational base, a collegial advisory group, and a channel of communication.[1]

If one physician and nurse are practicing together, they can constitute the joint practice committee. In larger settings membership should include nurse and physician representation and can extend to other health professionals and administrative personnel.

These local joint practice committees should establish written policies and standards of performance and review them periodically.[1] The committee also serves as an advisory and interpretive body to the various staffs in that setting.

Involvement in district, regional, and state joint practice efforts also is encouraged and helpful.

Are special credentials required for joint practice?

It is imperative that nurses in joint practice be educationally prepared and professionally competent for their extended function. They must be clinically competent and able to assume responsibility for their decisions and acts. Written evidence of the nurses educational preparation, experience, continuing education, and periodic evaluation should be on file and available for external review.

Educational programs for the preparation of registered nurse practitioners in extended roles should be developed by nursing in consultation with medicine and should be carried out, wherever possible, under the aegis of accredited educational institutions.[1]

Physicians need to examine their qualifications and readiness for joint practice, and not all nurses are professionally or personally prepared for such practice. Inadequacies in either professional are not conducive to success in joint practice.

How do the nurse and physician relate to each other in joint practice?

Interdependent relationships and willingness to reformulate roles are facilitated when practitioners are mature, experienced, and comfortable in their own role. Persons who need to define and defend professional territory and who operate with defensive attitudes are not good candidates for joint practice. The goal of joint practice is to improve health care, not to protect or preserve professional prerogatives. The success of joint practice is dependent on the attitudes, sincerity, and commitment of the persons involved.

Time and experience together are required to develop knowledge of each other, trust, and confidence. Mutual confidence is the crux of the relationship and will be communicated to others.

Certain mechanisms can assist the development of the relationship such as using problem-oriented records, periodically reviewing cases together, developing care plans jointly, and formally evaluating the pattern of relating to each other and caring for patients.

How do patients accept joint practice?

The focus of joint practice is on the needs of the patient and how the practice arrangement can meet them. Patient choice and preference continue to be preserved. The evident concern for the patient is conducive to acceptance.

The mutual respect and confidence in each other displayed by the physician and nurse are key determinants in patient acceptance.

Joint practice has evolved to improve the quality, availability, and accessibility of health care. If these ends are being achieved, greater patient satisfaction should be a consequence.

How is the quality of patient care maintained and improved?

Nurses and physicians, through collaboration, have the greatest potential to improve the quality, and increase the quantity, of health care.

State Medical Society of Wisconsin and Wisconsin Nurses Association

Statement on Joint Practice

Approved by the Council of the State Medical Society of Wisconsin, May 18, 1974, and endorsed by the October 9-11, 1974 WNA House of Delegates and the State of Wisconsin Board of Nursing. The Medical Examining Board recognizes the need for the development of joint practice arrangements in accord with the principles enumerated in the Statement.

THIS STATEMENT embodies guiding principles and professional opinion on elements of joint practice by physicians and registered nurses in any setting. The authority of the Statement testifies to mutually agreed upon principles of practice. The Statement can be used to validate generally acceptable practices or patterns of care and to respond effectively and responsibly to new needs and methods of providing care.[1]

The State Medical Society of Wisconsin and Wisconsin Nurses Association cannot through this Statement alter the legal authority of the physician or registered nurse. However, the application of the following principles of joint practice can substantially improve the quality, availability and accessibility of health care for the people of Wisconsin.

- The health and best interest of the recipients of care are foremost considerations in all practice arrangements.

- The degree of professional responsibility vested in the physician or registered nurse is related to education, experience, competence, and licensure. Each practitioner should perform only those acts for which that person has been prepared and has demonstrated ability to perform.

- Medical and nursing services are complementary but they are not interchangeable either in responsibility or accountability. Each practitioner is accountable and responsible for the quality of care rendered. Each practitioner is responsible for the maintenance and improvement of practice proficiency.

- Each practitioner should receive remuneration commensurate with qualifications and proficiency.

- Medical and nursing collaboration includes both independent and cooperative decision-making. Mutually developed protocols can clarify shared responsibilities and delegated functions.

- Educational programs for the preparation of registered nurse practitioners in extended roles should be developed by nursing in consultation with medicine and should be carried out, wherever possible, under the aegis of accredited educational institutions.

- It is advantageous to have physicians and registered nurses affiliate in joint practice committees in order to provide both with an organizational base, a collegial advisory group, and a channel of communication.

- In each health care delivery setting involving the practice of registered nurses and physicians, a joint practice committee should establish written policies and standards of performance. Such policies and standards should be reviewed periodically.

- It is important to maintain a flexible and innovative approach in the evolving role realignment of registered nurses and physicians. Differences in recipient populations, in how they are served, and in the composition of practitioners working in a setting, will influence what each practitioner regularly does.

1. In developing this Statement the joint position statements on practice of the following medical and nurses associations were consulted and utilized: California, Canada, Florida and Idaho.

The health and best interest of the patient remains the foremost consideration in all practice arrangements.[1]

Each practitioner is accountable to the patient and to each other for the quality of care rendered individually and collectively.

The local joint practice committee should establish written policies and standards of performance and systematically review those standards and resultant care periodically. Evidence of the review should be maintained. The committee should make recommendations for improvement of care and monitor their implementation.

Are protocols necessary?

Medical and nursing collaboration includes both independent and cooperative decision-making. Mutually developed protocols can clarify shared responsibilities and delegated functions.[1] Protocols are helpful for practical purposes, for insuring quality, and for legal reference if required.

Published protocols are increasingly available for reference in professional journals and books. Consultation also can be obtained for the development and review of protocols. Protocols should be reviewed and updated regularly.

A general protocol should be available which describes how the nurse and physician in that setting practice with each other.

How does joint practice affect professional liability?

The physician has definitive legal responsibility and ultimate accountability in matters of medical care. However, the nurse shares in this accountability and remains legally responsible for decisions and actions in the practice of nursing. Each practitioner should be properly identified to the patient.

All professionals are expected to exercise judgment about the limits of their individual competence. Each practitioner should perform only those acts for which that person has been prepared and has demonstrated ability to perform. Each practitioner is responsible for maintenance and improvement of practice proficiency.[1]

There is no evidence of an increase in malpractice suits stemming from joint practice. Joint practice can lessen malpractice concerns because of improved, complementary care and shared accountability.

The Joint Practice Statement is admissible as evidence in court. If the practitioners are observing the guidelines in the Statement, they are practicing the "best care available" at the time.

What is the legal base for joint practice?

Practice acts (licensing laws) were enacted in the public interest to safeguard care and are not primarily for the protection of the practitioner.

The present medical and nurse practice acts in Wisconsin permit joint practice. The nurse functions under the nurse practice act and not under the physician assistant portion of the medical practice act.

Practice acts are phrased in broad terms to accommodate changes and advances without the necessity for statutory revision. The National Joint Practice Commission recommends that "practice acts which are broad enough to permit flexibility within the confines of licensure be left as they are and that statements addressing themselves to the issues of role realignment and adjustment be initiated by State Joint Practice Committees or other joint bodies of medicine and nursing.[2]

A joint practice statement embodies guiding principles and professional opinion on elements of joint practice by physicians and registered nurses in any setting. The authority of the Statement testifies to mutually agreed upon principles of practice. The Statement can be used to validate generally acceptable practices or patterns of care and to respond effectively and responsibly to new needs and methods of providing care.[1]

The degree of porefessional responsibility vested in the physician or registered nurse is related to education, experience, competence, and licensure.[1]

How does joint practice affect the organization for care?

Both nurses and physicians should participate in committees which focus on patient care and the practice environment and organization. They also should be directly involved or represented in the administrative structure. Their active participation in community activities related to health care will enable interpretation of joint practice along with their broader contribution.

The nurse needs space, privacy, furniture, and equipment to enable assessment of, and conferencing with, patients. Other facilitating arrangements may include alternate examining rooms and a health education room.

Components in the practice should be evaluated for enlargement, enhancement, or initiation such as patient education; periodic examinations; visits to homes, nursing homes, or other residential settings; conferences with other care providers in the community, family oriented practice, and satellite possibilities.

Various scheduling patterns evolve in accord with individual and practice factors. The nurse may perform the initial assessment and triage of patients, provide ongoing supervision of patients within mutually developed protocols, and develop a specific caseload. Some practitioners prefer alternation of visits between the physician and nurse with consultation as needed. The nurse may share on-call responsibilities.

Patient choice is preserved.

Maintaining continuity and rapport are important.

Joint practice shoud provide something more, not less.

What about patient charges?

Patient charges are determined by the providers involved. In some settings there is a uniform charge no matter who provides the service. The fee schedule for a joint practice should be arrived at jointly.

Third party payment also enters into the consideration of patient charges. Some third party payers directly reimburse the services of nurse practitioners.

Health education costs must be included in reimbursement plans.

How is the nurse compensated?

Each practitioner should receive remuneration commensurate with qualifications and proficiency.[1]

Some nurses receive a salary; others are part of the corporate structure. The contribution of the nurse should be reflected in the productivity of the practice. The compensation of the nurse should be individually negotiated and reflect the responsibility assumed.

What about staff privileges at hospitals and other institutions?

Institutional acceptance and implementation of joint practice is important and worth the effort.

The statutes and joint practice statements authorize joint practice, but specific delineation of privileges is left to the hospital or other facility. Privileges should be collaboratively determined and granted by nursing and medical staff. It is the spirit of these privileges that the nurse will work with, not in place of, the physician.

What other measures are helpful in interpreting joint practice?

Explanation of the purpose and methods of joint practice to patients, their families, other physicians and nurses, office and administrative personnel, other care providers, pharmacists, and the general public can be helpful.

Demonstrated skill is more convincing than explanation.

Any other suggestions?

Historically, there has been a continual realignment of the functions of the nurse and physician. The rising demand for health services and the increased competence of nurses are hastening this transition. However, external events and statutes facilitate joint practice; they do not impose or guarantee it. Joint practice can be achieved only by the practitioners involved.

Role innovation may be easier where physicians are scarce, but the joint practice model has validity and advantages in most, if not all, settings.

A last suggestion would be to emphasize the importance of remaining open and flexible in order to respond to needs, to make adaptation, and to realize more fully the evolving contributions of the practitioners involved.

REFERENCES

1. State Medical Society of Wisconsin and Wisconsin Nurses Association Statement on Joint Practice, 1974 (see adjacent box).
2. National Joint Practice Commission. *NJPC Statement on Medical and Nurse Practice Acts.* Chicago: The Commission, 1974. ■

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, alleged father and others to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissable. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

MALPRACTICE PENALTIES FOR THE UNLICENSED

Section 448.12 of the Wisconsin Statutes, quoted below, is concerned with legal consequences to those who "treat the sick" without or beyond the limits of a license or certificate of registration. One such consequence is full liability for the penalties of malpractice even where it is the result of ignorance rather than negligence or lack of skill. The wording covers failure to perform or attempt to perform as well as actual performance.

The statute has application to such persons as chiropractors, podiatrists, or optometrists when they exceed their respective limited licenses or certificates.

Section 448.12 reads as follows:

> "Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the sick without having a license or a certificate of registration, shall be liable to the penalties and liabilities for malpractice; and ignorance shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners."

Problems of a Physician's Widow

FOLLOWING THE LOSS of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow will be faced with many decisions involving the settlement of the business affairs relating to her late husband's practice. It is of extreme importance that she act upon the advice of an attorney. When practical it is recommended that the physician acquaint his wife with his legal and other advisors and some of his business affairs. This will provide an established working business relationship between the wife and the advisors for that eventuality when she is called upon to act. Some of the chief problem areas the widow will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow also will be presented with the problem of what to do with the physician's narcotics. The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

> "The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration, 517 East Wisconsin Ave, Room 228A, Milwaukee, Wisconsin 53202; (414) 224-3395.

It is important that a widow, other members of the family, and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his death may be obtained from the Wisconsin Pharmacy Examining Board, 1400 E Washington Ave, Madison, Wis 53702.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should not be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow can expect that the deceased physician's patient will seek care elsewhere unless he had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In such event, it is wise to insist upon a written request from the patient and his new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow's legal and other advisors can best inform her how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. She should carefully follow her attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow or the heirs to enforce collection by suit within such period. She should also seek legal and accounting advice on how long to retain the financial records of her late husband. It is quite possible that his estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

A widow should consult her attorney as to whether

the estate needs to arrange a malpractice policy buy-out with the deceased physician's carrier so as to protect the estate assets and the widow's share of such assets. Some physicians will have attempted to do this during lifetime and if they did so this will be evident from study of the policy, its endorsements and correspondence. If there is uncertainty in the matter, the attorney should contact the insurance carrier and seek its cooperation in ascertaining the facts. The reason for this is that a suit can be maintained against the estate and heirs of a deceased physician who is alleged to have committed one or more acts of professional negligence with resultant injury to a patient.

The State Medical Society office is always available for consultation with a widow, her family or the estate attorney. ■

AMPHETAMINE ABUSE IN WISCONSIN

The Controlled Substances Board of the State Department of Health and Social Services acquired specific purchase data in Wisconsin of one amphetamine product—Biphetamine-20. These data pertain to calendar year 1975 and indicated that 916,500 dosage units were purchased by Wisconsin registrants during that period.

In the resultant report there were certain recommendations including the suggestion that the State Medical Society emphasize once again its position that physicians limit the prescription and dispensing of amphetamines to recognized conditions where these drugs are indicated.

The report was transmitted to the State Medical Society and assigned to the Commission on Peer Review. At the request of the Commission Doctors John McAndrew and Joseph Grace were asked to draft an appropriate statement for publication. Doctors McAndrew and Grace, in consultation with Doctor Darold A Treffert, developed the following statement indicating that the current usage should be limited as follows:

ACCEPTABLE:

(1) Symptomatic Narcolepsy

(2) Selected cases of minimal brain damage with hyperactivity in children.

PROBABLY ACCEPTABLE:

(1) Antagonism of anticonvulsant's depressive effect

(2) Prediction of tricyclic antidepressant response

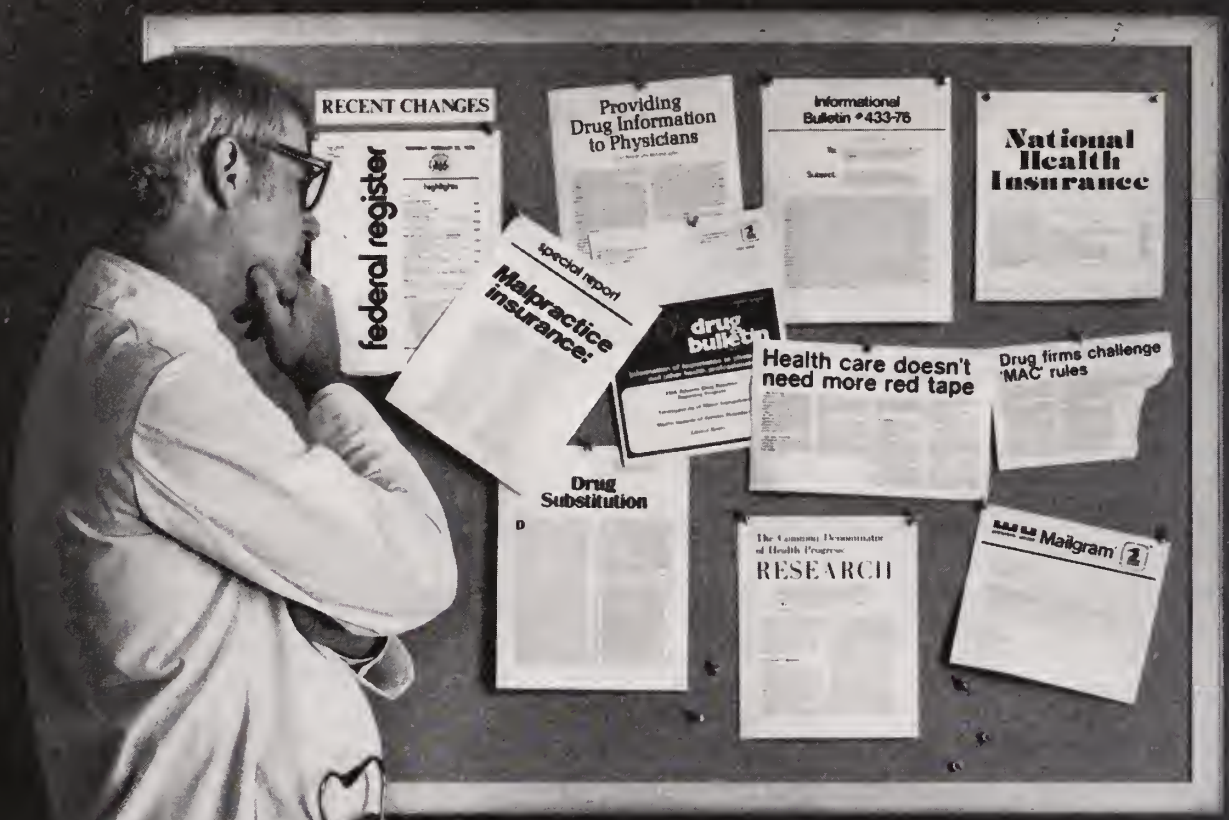
(3) Supplement to tricyclic drugs when side effects prevent adequate tricyclic dosage for therapeutic response

RARELY ACCEPTABLE:

(1) Short term use (e.g. 6 weeks) for resistant obesity associated with depression concomitant with a restricted calorie diet and close physician control.

NOTE: The data compiled in cooperation with the US Department of Justice Drug Enforcement Agency (DEA) identify 465 pharmacies and 26 practitioners as ordering Biphetamine-20 in 1975. Among the practitioners were 23 physicians (MD and DO), two dentists, and one podiatrist. The Wisconsin Controlled Substances Board is expanding its survey scope to include all Schedule 2 amphetamines and hypnotics. Moreover, the Board of Controlled Substances is considering formal audits of several of the top purchasers among practitioners and pharmacies and the State Medical Examining Board is considering the development of an administrative rule which will restrict the purchase of amphetamines.

The above statement was approved by the Council of the State Medical Society of Wisconsin, June 4, 1977


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

MEDICAL LICENSURE AND FINANCIAL RESPONSIBILITY

SEVERAL STATUTES have been enacted during the current legislative session which affect the licensure of physicians and which require, with some exceptions, proof of financial responsibility, as well as continuing education. These include Chapters 2, 37, Supplement to Chapter 37, and Chapter 79 to name a few. Additional modifications were embodied in Senate Bill 755 signed by the Governor on April 29, 1976 which was designated as Chapter 224.

Wisconsin Health Care Liability Insurance Plan

The Wisconsin Health Care Liability Insurance Plan was created as a market to provide professional liability insurance protection for those who are unable to purchase it in the private market. This Plan is administered by a Board of Governors comprised of eleven persons, one of whom is a physician.

In view of the foregoing plus the possibility of future legislation, this article will attempt only to highlight the essential new provisions. As additional developments occur they will be reported on a timely basis to the membership. Additionally, the State Medical Society will maintain a special file for the benefit of new physicians as they enter the state and become affiliated with the Society.

Professional Liability Insurance —Minimum Required Coverage

One of the three ways the "financial responsibility" requirement may be met is to carry basic coverage in the amount of $100,000/$300,000 limits. The other alternatives are to qualify as a self-insurer or post a cash or surety bond both of which are subject to the approval of the Insurance Commissioner.

Professional Liability Insurance —Recommended Coverage

$200,000/$600,000—These amounts are the extent of liability for those who otherwise qualify under the applicable statutes. These limits are recommended because any awards in excess of these amounts become the responsibility of the Patients Compensation Fund as created by Chapter 37.

Patients Compensation Fund and Hearing Panels

This fund was established as a resource for payment of any awards in excess of the $200,000/$600,000 limits. In substance it is the equivalent of and replaces the "umbrella" coverage previously carried by many physicians.

Special Assessments

There are two. One is in the amount of 5% of what the physician would pay for $200,000/$600,000 limits basic coverage if purchased through the Wisconsin Health Care Liability Insurance Plan. The other is $40 to support the hearing panels to which submissions of controversy (claims) are referred for initial adjudication.

Appeal Process Available

Physicians who question their assessments to support the Patients Compensation Fund have an appeal process available to them. Two physicians serve in this capacity along with a representative of the Office of the Insurance Commissioner. Appeals should be addressed to: Chief, Patients Compensation Fund, Department of Insurance, 123 West Washington Ave, Madison, Wis 53702.

Continuing Education

Chapter 224 now requires 45 hours of continuing education during a three-year period. This supersedes the initial requirement of 15 hours each year as a condition of licensure.

Exemption

A physician may be exempted from the requirements as well as the benefits of these laws if s/he practices less than 240 hours in any year.

Special Consideration

To accommodate those who wish to restrict or limit their practices a special rate is available to those who maintain an office-only-practice of less than 500 hours per year.

General Comment

Chapter 37, Laws of 1975 created a special legislative study committee which has broad responsibilities including the requirement of reporting its findings and recommendations to the legislature. New legislation has been introduced in the 1977 session.

It is anticipated that the Board of Governors will be considering and authorizing modifications on an interim basis which will be reported to the profession on a timely basis. Additional information including the availability of a pamphlet describing the newly created hearing panel process may be obtained upon request to the Society. ■

Adoption

STATE LAW REGULATES the adoption of children and licenses the agencies involved in adoptive placements to the problems and abuses inherent in "black market" adoptions.

Licensed private child welfare agencies and special governmental agencies are authorized to take custody of children, become their guardians, provide care and maintenance for them, place them in foster homes (which must also be licensed) and initiate necessary steps leading to adoption.

No one else may perform these functions in the adoptive process and the physician must be careful to refer patients either having a child for adoption or seeking to adopt to the appropriate agencies. (See box on this page.)

Placement of a child for adoption or receipt of such a placement may subject those involved, including an intermediary, to criminal prosecution. Failure of the parties to follow legally established procedures for adoption is grounds for a court to refuse to grant the adoption.

Similar precautions are taken with interstate adoption situations and consent must be obtained from the Department of Health and Social Services before any child is brought into Wisconsin or sent from this state for adoption. ■

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Inquiries concerning national advertising copy should be directed to:

STATE MEDICAL JOURNAL ADVERTISING BUREAU, 711 South Blvd, Oak Park, Ill. 60302; or local (Wisconsin only) advertising copy to: WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin 53701.

The *Wisconsin Medical Journal* is one of 40 state medical journals published monthly in the United States. These journals represent 47 state medical societies. Each is an official publication of the state society it represents, and is owned and operated by it.

The *Wisconsin Medical Journal* has a circulation of more than 5,000. About 80 percent of the physicians in Wisconsin receive the Journal as part of their Society membership dues. Others who receive the Journal, either complimentary or through paid subscriptions, include senior medical school students at the University of Wisconsin and Medical College of Wisconsin, hospital administrators, faculty members of the two medical schools, medical clinic managers, most major medical school libraries in the United States and abroad, prominent physicians in the United States, health-related government agencies, and other health organizations in Wisconsin and the United States.

REFER CHILD ADOPTION CASES TO THESE LICENSED AND PUBLIC AGENCIES

LICENSED CHILD WELFARE AGENCIES:

Wisconsin Lutheran Child and Family Service, Inc. 6800 North 76th Street, Milwaukee 53223.

*Children's Service Society of Wisconsin, 610 North Jackson Street, Milwaukee 53202.

Catholic Social Services, 207 East Michigan Street, Milwaukee 53202.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse 54601.

Catholic Social Service, 25 S. Hancock, Madison 53703.

Catholic Social Services, 131 South Madison Street, Green Bay 54305.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 53213.

Lutheran Social Services of Wisconsin and Upper Michigan, 3200 West Highland Boulevard, Milwaukee 53208.

Seven Sorrows of Our Sorrowful Mother Infants' Home Necedah 54646.

PUBLIC AGENCIES:

*Division of Family Services (See page 92 for list of Regional Offices).

*Milwaukee County Department of Public Welfare, Child Welfare Division, 1220 West Vliet Street, Milwaukee 53205.

* Nondenominational.

MATERNITY HOMES

Lutheran Maternity Home, 1910 South Avenue, La Crosse 54601.

Booth Memorial Hospital, 6306 Cedar Street, Wauwatosa 53213.

Rosalie Manor, 19305 West North Ave., Brookfield 53005.

St Francis Maternity Residence, 709 S Tenth St, La Crosse, 54601.

MEDICOLEGAL FIRST AID

THE CONTINUING AND RAPID scientific advances coupled with the increased demands and expectations of patients frequently results in an imbalance between the art and science of medicine. A proper blending of the art and science by the practicing physician and his associates contributes much in the way of patient and professional satisfaction.

Throughout the land professional liability insurance carriers are announcing substantial premium increases; some are limiting their coverage to lesser risk classifications; and others are withdrawing entirely from writing this category of protection.

From all the Council's Committee on Economic Medicine can ascertain, the professional liability insurance market is less restricted in Wisconsin than it is in several other jurisdictions. Even so, SMS members are required to pay substantial premium rates for this protection which is so essential to the practice of medicine.

The Committee on Economic Medicine continues its efforts to keep abreast of developments in this important area and offers the following points to physicians.

I. Keep your expired professional liability policies

Comment: The standard three-year Statute of Limitation is not applicable to minors or incompetents. You may be sued many years after the alleged event. Possession of the policy will be invaluable or you may face the defense alone at your own expense.

II. Keep good records and retain them for years

Comment: See Comment to No. I. In any event retain records in *all* cases for a minimum of six (6) years after date of last treatment. As to the special situations presented by minors and the mentally ill or incompetent, see your personal attorney.

III. Advise patients as to risk involved in not only operative procedures, but also as to side effects of drugs prescribed or administered; this is frequently called "Informed Consent"

Comment: The legal test appears to be "What would the average prudent person in the patient's position have decided if informed of the perils?" No longer is the legal test what the *physician* believes the patient or his representative should know about the risks of the patient.

IV. The "Locality Rule" has been abolished in Wisconsin

Comment: The practitioner be he "generalist" or "specialist" is now subject to liability in an action for negligence if he fails to exercise that degree of care and skill which is exercised by the average practitioner in a class to which he belongs, acting in the same or similar circumstances. Geographical area and its attendant lack of facilities are circumstances that can be considered if appropriate.

V. Continued membership in your Society is recognized by the Courts as vital for continuing education

Comment: The Courts state that there is no lack of opportunity to keep abreast of the advances made in the medical profession and cites the AMA JOURNAL as authority. The same reasoning applies to SMS JOURNAL and the Society's continuing education programs.

VI. Refrain from ill-advised remarks; THINK BEFORE YOU SPEAK

Comment: Many of the malpractice cases have their genesis in the unfortunate thoughtless spontaneous statements of a nurse, a technician or a physician. Warn your employees and assistants to be on the alert at *all* times.

VII. Give prompt notice to insurer in the event of an "incident"

Comment: Should there be any occurrence in the patient-physician relationship which might result in either a claim or litigation, give prompt notice to the carrier. Timely notice and prompt investigation are far superior to waiting for a formal summons.

VIII. Provide Continuity of Care

Comment: Once a physician accepts a patient which requires a course of treatment he should pursue the plan of prescribed care. If the physician is to be out of the area for an extended period he should arrange for suitable coverage and so notify the patient. Should the patient fail to complete the prescribed plan of care, the physician should follow-up and; in either event this should be documented in the patient's record.

IX. Be alert to the suit-prone "litigious" patient

Comment: Some patients have a tendency to be hypercritical of physicians who have previously treated them. Others may have unrealistic expectations of good or perfect results of medical care. In such situations, extreme caution should be exercised so as to minimize the probability that you or a physician who has treated the patient previously will become involved in a liability claim or suit.

X. Avoid discussion of your liability insurance

Comment: The knowledge that you carry insurance *may* precipitate a claim should an unanticipated complication arise or if the patient becomes dissatisfied with the results of a course of treatment.

XI. Always exercise discretion in the collection of accounts

Comment: Turning a delinquent account over to a collection agency — especially if there is any evidence of patient dissatisfaction may well be the basis for a counter charge in the form of a suit against the physician. While the physician is entitled to remuneration for professional services rendered, foregoing payment may be less of a loss than being a defendant in a lawsuit.

XII. Avoid direct contact with a plaintiff's attorney

Comment: In the event of a claim or suit and the plaintiff's attorney attempts to contact you, you are well advised to refer him to your own attorney. Any communication you may have with a plaintiff's attorney — no matter how well intentioned — might very well compromise your defense if the case proceeds to litigation.

The Committee on Economic Medicine will continue to monitor current literature relating to medical professional liability claims to ascertain additional factors which may give rise to suits against physicians. As they are identified, they will be communicated to you through the GREEN SHEET and in other ways. In the interim physicians are encouraged to communicate any helpful hints to the committee so they may be shared with your colleagues in furtherance of both the public and professional interest. ■

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MEDICAID

- SMS sued the State Department of Health and Social Services, charging the department illegally instituted a freeze on the level of Medicaid payments to physicians. Dane County Circuit Court Judge P Charles Jones ruled in favor of the Society, and issued an injunction preventing the State from continuing the freeze.

- SMS challenged anyone, anywhere with knowledge or evidence of Medicaid fraud by consumers of providers to contact the State Medical Society for an investigation of any allegations.

- SMS continues to negotiate with the State Department of Health and Social Services in the development of a provider manual for Title 19 programs.

PROFESSIONAL LIABILITY

- SAVED money for physicians who obtain their basic coverage under the Wisconsin Health Care Liability Plan. SMS involvement in the rate-setting sessions resulted in a **15% reduction** in premiums, effective July 1977. Yearly reduction for physicians' premiums in the Plan total approximately **$1,200,000.**

- SAVED money for **all** physicians in the form of a 50% reduction in the assessments for the Patients Compensation Fund (umbrella coverage). Beginning in July 1977, the assessment will be 5% (rather than 10%) of the premium a physician would pay for insurance with the Plan. Yearly savings for Fund assessments total approximately **$1,000,000.**

- SAVED money for physicians in the form of surcharges in the Plan for malpractice suits filed against them. As of July, the surcharging system will be eliminated. Yearly savings projected for the dropped surcharge equals **$50,000.**

TOTAL YEARLY SAVINGS
TO PHYSICIANS $2,250,000

- FORMULATED a legislative "package" which would revise current professional liability statutes in Wisconsin. Key elements of the program include revisions of the statute of limitations statute, and a proposal which would provide for voluntary binding arbitration as one means of settling a professional liability dispute.

- SUPPORTED three additional bills being considered by the Legislature this session: **AB 704,** which requires all physicians to complete 45 hours of continuing medical education by 1980, authorizes the Plan to write a second layer of coverage ($100,000/300,000), clarifies the composition of the Patients Compensation Panels, transfers administrative responsibilities under Ch 655 to the Commissioner of Insurance, includes hospital-based nursing home beds in the State Plan and Fund, and allows state and local employes and facilities that are "health care providers" the option of participating in the Fund, and changes the notice time for cancellation or nonrenewal of Plan policies from 60 to 10 days. **AB 705,** which reduces the statute of limitations for Minors from age 19 to age 8, or the adult statute of 3 years from occurrence, whichever is later in time for professional liability claims. (These two bills were formulated as a result of the work of a special legislative committee on malpractice. The State Medical Society was represented on this Legislative Malpractice Committee. **AB 237,** which defines frivolous suits for all areas of liability and provides for the recovery of defense costs.

- STUDIED options available to physicians who believe they are involved in unfounded medical liability suits or that insurance companies have failed to provide them with good faith defense. Fifteen cases have been received and considered by the Physicians Alliance Medical Defense Committee. Activities of the Medical Defense Committee include liaison with the State Bar Grievance Committee and with the Director of the Patients Compensation Panels, and information gathering sessions with insurance industry representatives.

- COSPONSORED a health symposium with the Wisconsin Center for Public Policy and the State Department of Health and Social Services on health care costs and delivery where defensive medicine and other areas of medical liability were presented and discussed.

- PARTICIPATES in many legislative, Wisconsin Health Care Liability Plan, and other government-private committees concerned with professional liability, and ATTENDS various statewide and national seminars on professional liability and reparations systems.

- COSPONSORED a Reparations Conference at Oconomowoc, bringing together experts in the fields of tort liability and professional liability insurance.

PUBLIC AFFAIRS

- COSPONSORED (with the Wisconsin Center for Public Policy) a major health symposium, bringing together experts from the state and national levels, who concentrated on reasons behind rising health care costs.

- CONTINUED to study health care in Wisconsin county jails, and began to compile standards for proper care for inmates. Wisconsin is one of six states selected by the AMA to receive a grant for this study.

- CONTINUED to promote rural health, improved distribution of physicians in rural Wisconsin, and expansion of primary care.

COMMUNICATIONS

- PRODUCED and distributed a brochure explaining reasons behind rising health care costs, particularly

physician fees. These brochures, provided free, are distributed through physician offices.

- KEPT membership totally informed of organizational news, via the *Wisconsin Medical Journal,* the Medical GREEN SHEET, Leaders Letter, and several membership mailings. The WMJ and GREEN SHEET are mailed monthly to all members, occasionally there are extra GREEN SHEET issues. The Leaders Letter goes, First Class mail, to leaders and the most active members of the Society on a weekly basis.
- INTRODUCED *Capitol Week,* which is mailed to Society leaders and to any physician particularly interested in legislative matters. This weekly publication, sent First Class mail, informs members of all the health-related and SMS-related legislative activity at the Capitol during the preceding week.
- CLOSER liaison with the news media is a key aim of the Communications Department. Regular press conferences, news releases, and contact between physicians and reporters are key elements in this area. ■

Worker's Compensation and the Physician

VIRTUALLY EVERY physician practicing in Wisconsin becomes involved with treatment of a patient covered by Worker's Compensation. This law provides payment of compensation for disability and expense for medical attention necessary because of injury or illness sustained in the course of and arising out of employment.

Please contact either the State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701 [tel (608) 257-6781] or N J Taugher, Administrator of the Worker's Compensation Division, 201 East Washington Avenue, Box 7901, Madison, Wis 53707 [tel (608) 266-1340], if you have any questions.

Four points of advice will aid every physician in dealing with Worker's Comp.:

★ Learn how to estimate disability according to the standards set up by the Department of Industry, Labor, and Human Relations. Other standards or schedules are fine for your own information, but only the Department's standards are authoritative in Wisconsin (see "New Rules Established for Estimating Disabilities in Workmen's Compensation Cases" which appeared in the June 1975 Blue Book, pp 43-45).

★ Submit your reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. Quite often the unexpected misfortune places the employe in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

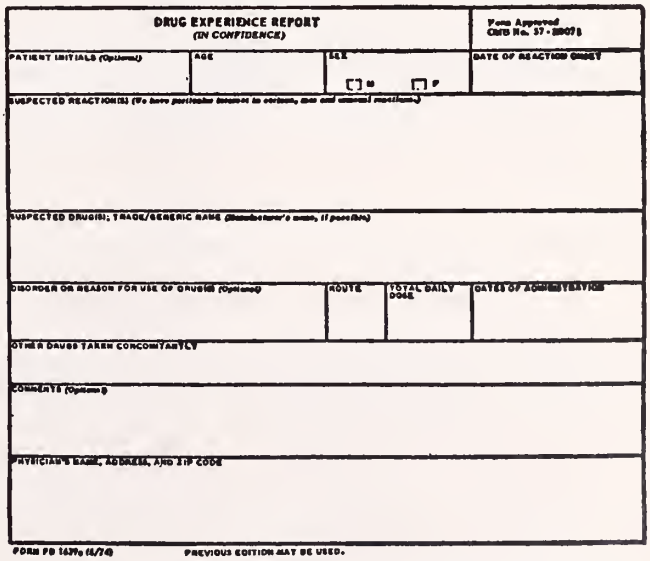
★ Don't be afraid to ask questions. Contact either the State Medical Society or N J Taugher at the addresses noted above. ■

FDA Adverse Drug Reaction Reporting Program

THE FOOD AND DRUG Administration is obligated by law to monitor the safety and effectiveness of marketed drugs which they do through a voluntary adverse drug reaction reporting system. The FDA has over 129,000 adverse drug reaction reports stored in computer-retrievable form, at present. However, physicians should continue to report adverse drug reactions to the FDA so that information remains current and reflects the new uses of older drugs as well as uses of recently marketed drugs. The FDA has a particular interest in serious, life-threatening, and fatal reactions. For reporting purposes, such incidents must be unequivocally drug-related.

All health professionals are urged to report adverse drug reactions. While these reports are available to the public, information identifying the patient and the reporting physician or hospital is held in confidence and protected by Freedom of Information Regulation.

To facilitate reporting, a "Drug Experience Report" Form 1639A has been developed. Known as the "Short Form," physicians can obtain these forms by writing: FDA,


DRUG EXPERIENCE REPORT
(IN CONFIDENCE)

Form Approved
Care No. 57-[illegible]

PATIENT INITIALS (Optional) | AGE | SEX [ ] M [ ] F | DATE OF REACTION ONSET

SUSPECTED REACTION(S) (Give brief particular description in certain, clear and unusual manifestations.)

SUSPECTED DRUG(S); TRADE/GENERIC NAME (Manufacturer's name, if possible)

DISORDER OR REASON FOR USE OF DRUG(S) (Optional) | ROUTE | TOTAL DAILY DOSE | DATES OF ADMINISTRATION

OTHER DRUGS TAKEN CONCOMITANTLY

COMMENTS (Optional)

PHYSICIAN'S NAME, ADDRESS, AND ZIP CODE

FORM FD 1639A (6/74) PREVIOUS EDITION MAY BE USED.

Bureau of Drugs, Division of Drug Experience (HFD-210), 5600 Fishers Ln., Rockville, Maryland 20857. ■

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

NOTE ON ss. 148.03, 447.13, 449.15 and 450.13; Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation. ■

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to bring into one compact organization the entire medical profession of the state of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote open communication and understanding among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

*COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through April 1977.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors, immediate past president, president, president-elect, speaker and vice-speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Council, but without the right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members, and in March 1976 to add the president-elect and vice-speaker. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called.

COMMENT: Section 3 was amended in May, 1965.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from eight districts, and a speaker and vice-speaker of the House of Delegates.

Each councilor shall be nominated and elected only by the elected delegates of the county medical society or societies for the councilor district in which he has his principal place of practice. Such election shall be subject to the approval and confirmation of the House of Delegates.

No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph; second paragraph amended in March 1973. Number of districts reduced from thirteen to eight in April 1975.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. No individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and no more than a total of six terms of service as councilor shall be permitted. There shall be elected one councilor for each of the eight districts, except that in any councilor district embracing a membership of 200 or more, there shall be elected one additional councilor for each additional 200 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years. The fourth sentence on number of councilor terms was added in May 1965. Number of members used as basis for councilor representation changed from 250 to 200 in April 1975.

As nearly as possible, one-third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

SEC. 4. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician, who holds an unlimited license to practice medicine and surgery, and whose principal practice is within the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of Constitution and Bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have practiced within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked, suspended, or voluntarily surrendered, shall be dropped from membership automatically as of the date of revocation, suspension, or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician's county society membership must be held in that county in which his principal practice is located. However, a physician living near a county line may hold his membership in that county most convenient for him to attend meetings, on permission of the component society in which county he maintains his principal place of practice.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election. Such resident members shall have the right to vote and hold office.

Sec. 5. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

Sec. 6. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member during term of service or for the balance of the year following separation from active duty. Special service membership shall lapse at the close of the calendar year of the separation of each such member from active duty.

Sec. 7. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

Sec. 8. *Honorary Membership.* Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

Sec. 9. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

Sec. 10. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, or who practices less than six (6) weeks per year, is eligible for associate membership. With approval of his county society and of the Council, such membership shall be granted without payment of annual dues.

Sec. 11. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

Sec. 12. *Military Service Membership.* Members who are inducted into active United States military service shall be granted military service membership. Dues for such member are waived during term of service and for the balance of the year following separation from active duty.

Sec. 13. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the *Wisconsin Medical Journal,* and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

Comment: Section 13, above, was created by the Council as Resolution No. 27 and adopted by the House of Delegates in May 1964.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

COMMENT: Section 2 on publication of scientific papers rescinded in May 1972.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

COMMENT: In May 1964 this section was amended to call for an interim session, but in May 1966 this provision was repealed effective January 1, 1967.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each forty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

COMMENT: Number used as basis for determining representation changed from fifty to forty in May 1966; second paragraph of Section 2, below, amended in March 1973.

The term "full-paid members" as used in this section includes regular members of the Society, life members, affiliate members, associate members, educational members, resident members, honorary members, special service members, and members whose dues are waived or remitted by official action of the Society. Members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provision.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.
e. On Finances.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate for each district, except that in any councilor district embracing a membership of 500 or more, there shall be elected one additional delegate for each additional 500 members or major fraction thereof, and one delegate representing all of the specialty sections. This newly elected committee shall become operative at the close of the final meeting of that annual session, and shall function until the close of the final meeting of the following year's annual session. The incoming committee shall meet with the existing committee, but without vote, during the overlapping days of the annual session. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at the next annual session. No two candidates for president-elect shall be from the same district.

The Committee on Nominations shall convene at least two months prior to the annual session of the House of Delegates to prepare a slate of candidates. This meeting, to be held at the Society headquarters, shall include an open session of not less than one hour to allow individual nomination of candidates. Any vacancy occurring in the Committee on Nominations between the date of its election and the time of its reporting shall be filled by appointment by the councilor or councilors of the councilor district in which the vacancy occurs; provided that if the vacancy occurs in the representation from the specialty sections, such vacancy shall be filled by ballot of the several section chairmen.

COMMENT: Section 1 amended in March 1973; first sentence of paragraph one further amended in April 1975; section further amended in March 1976.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. The House of Delegates shall elect the president-elect, speaker and vice-speaker of the House of Delegates, and delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the legal votes cast shall be necessary to elect. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie for the lowest number of votes and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of *Wisconsin Medical Journal).*

In March 1973 the House reaffirmed the above and stated that as general manager, the secretary is in charge of all Society divisions, activities, and personnel.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of

the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the *Journal* and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice-chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMISSIONS AND COMMITTEES

SECTION 1. The Council shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary properly to conduct the affairs of the Society. Each commission and committee shall have the duty of keeping currently informed on matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities for improvement; of determining the best solutions it can to the specific matters referred to it; of contributing in its area to the achievements of the Society and its members in the protection and improvement of the quality of life for the whole human family; and finally, of making all its efforts useful by passing on to the Society's Council or House of Delegates in the most effective manner possible the results of its studies and activities with appropriate recommendations for action. In addition, each commission or committee shall represent the Society's interests by continuing contacts with voluntary and governmental agencies having related concerns with a view to coordinated efforts serving the best health interests of the people of Wisconsin.

SEC. 2. Specialty sections. The specialty sections shall be regarded as special committees of the Society to which the Council or any commission or committee may turn for advice and assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of the talents available through these sections and their related specialty societies.

COMMENT: This Chapter repealed and re-created in April 1975.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership.

Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall be deemed delinquent until his name is properly reported and his dues for the current year are properly remitted. The name of any member who has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before October 15 shall be removed from the active membership rolls of his county society and this Society until his name is properly reported and all his dues for the year of enrollment are properly paid.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 3. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Sturgis Standard Code of Parliamentary Procedure.

CHAPTER XI

COUNTY SOCIETIES

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 4. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 5. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 6. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 6, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC. 7. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 8. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

CHAPTER XII

SPECIALTY SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such specialty sections within the Society as it may determine and

shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

SEC. 7. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VII of these Bylaws.

COMMENT: Section 7 added in April 1975.

CHAPTER XIII

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed. ■

PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION

Preamble

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community.

Adopted June 7, 1957 ■

STATE MEDICAL SOCIETY OF WISCONSIN

Accreditation Program

for Continuing Medical Education

Information is available in booklet form from: Coordinator, Dept of Continuing Medical Education, PO Box 1109, Madison, Wis 53701; tel 608/257-6781, ext 123. Pertinent excerpts follow:

☆ ☆ ☆

AMA Council on Medical Education defines six categories of learning activities that are acceptable toward the Physicians Recognition Award.

CATEGORY 1—CME activities with accredited sponsorship . . . Education activities that are a part of a planned program of continuing medical education and sponsored by an accredited organization . . . (including)

- Grand rounds
- Teaching rounds
- Departmental scientific meetings
- Seminars and Workshops
- Clinical Traineeships
- Mini-residencies
- Scientific sessions of medical specialty societies
- Visiting lecture programs
- Continuing medical education courses
- Audiovisual materials (under specified conditions).

CATEGORY 2—CME activities with non-accredited sponsorship (same activities as in Category 1, offered by a non-accredited medical organization. No formal approval is necessary for an organization to offer Category 2 credit).

CATEGORY 3—Medical training.

CATEGORY 4—Papers, publications, books, presentations, and exhibits.

CATEGORY 5—Non-supervised individual . . . activities (includes) self-learning, consultations, patient care review, self-assessment, specialty board preparation.

CATEGORY 6—Other meritorious learning experiences.

The State Medical Society of Wisconsin accreditation operates under the authority of the AMA Council on Medical Education and its Advisory Committee on CME. Accreditation by the SMSW is equivalent to action by AMA.

☆ ☆ ☆

WISCONSIN INSTITUTIONS AND ORGANIZATIONS ACCREDITED

by SMSW and AMA for continuing medical education programming at May 15, 1977

Bellin Memorial Hospital, Green Bay
Columbia Hospital, Milwaukee
Deaconess Hospital, Milwaukee
Howard Young Medical Center, Woodruff
Kenosha Memorial Hospital, Kenosha
Lakeland Hospital, Elkhorn
Luther Hospital, Eau Claire
Madison General Hospital, Madison
Memorial Hospital, Menomonie
Sacred Heart Hospital, Eau Claire
St Agnes Hospital, Fond du Lac
St Clare Hospital, Baraboo
St Joseph's Hospital and Marshfield Clinic, Marshfield
St Luke's Hospital, Milwaukee
St Mary's Hospital Medical Center, Madison
St Mary's Hospital, Milwaukee
St Mary's Hospital, Rhinelander
Waukesha Memorial Hospital, Waukesha
Winnebago Mental Health Institute, Winnebago

Fox Valley Academy of Medicine
The Milwaukee Academy of Surgery
Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
State Medical Society Section on Ophthalmology
Wisconsin Academy of Family Physicians
Wisconsin Allergy Society
Wisconsin Dermatological Society
Wisconsin Neurological Society
Wisconsin Orthopaedic Society
Wisconsin Otolaryngological Society
Wisconsin Surgical Society
Wisconsin Urological Society
Wisconsin Society of Critical Care Medicine
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
The Wisconsin Society of Radiation Oncologists

Marinette-Florence County Medical Society

AMA Accredited
Gundersen Clinic, LaCrosse
Dept CME, Medical College of Wisconsin, Milwaukee
Dept CME, University of Wisconsin Medical School, Madison
State Medical Society of Wisconsin
Wisconsin Society of Anesthesiologists

Life is short . . . Art is long . . . Experience is difficult

Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was created in 1955 to permit members and other friends to present gifts or grants to projects vitally affecting medicine and public health. Its initial fund was used for student loans, but the Foundation's scope of interest has grown with the increased volume of financial contributions to worthy projects.

STUDENT LOANS. Since its inception, the Student Loan Program has helped students prepare for careers in medicine, nursing, dentistry, pharmacy, and allied health fields. Funds for those loans have been given to the Foundation to administer according to the wishes of the donors.

CHARITABLE ASSISTANCE. Through the Foundation there is an opportunity for professional persons to assist their colleagues in need. Personal hardship strikes at physicians and their families as well as others.

MEDICAL STUDENT EXTERNSHIP PROGRAM. This is a newer Foundation project which has been highly successful. It provides a ten-week externship with a family physician for students who have completed their freshman year of medical school. Participating students receive fellowship grants from the Foundation.

RESEARCH ACTIVITY. Research projects on a variety of topics have been done with Foundation support. The Foundation is available to assist in planning, administering, and funding investigations of a scientific or medical soco-economic nature.

CONTINUING MEDICAL EDUCATION. Educational activity, in the form of postgraduate teaching programs, is a major thrust of the Foundation. Among these programs are a Speakers Service to county medical societies, regional "in-depth" programs, and special conferences and lectures on such subjects as medical aspects of mental retardation, prematurity, the newborn, stroke, and athletic injuries as well as many other medical subjects.

Since 1975, the continuing medical education programming of Wisconsin hospital and specialty groups has been accredited and supported by the Foundation.

OPPORTUNITIES FOR GIVING. Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Gifts may be unrestricted, restricted, or earmarked for specific purposes of interest to the donor.

In addition, service can be provided to those who wish to establish a Living Trust by naming the Foundation as trustee. Use of this mechanism can result in an immediate tax advantage for the donor while providing a guaranteed income for life. The principal would revert to the Foundation upon death of the donor.

ALL TYPES OF CONTRIBUTIONS TO THIS FOUNDATION ARE TAX-DEDUCTIBLE.

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY of the State Medical Society's CES Foundation is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy periodically publishes a newsletter that highlights the many contributions of medical memorabilia to the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 750 members now, it welcomes many more. The annual dues are only $5.00, payable to the CES Foundation—Academy of Medical History, Box 1109, Madison, Wis 53701.

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION
OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THE FOUNDATION is a non-profit, non-stock corporation under Wisconsin statutes. Governing power is vested in a Board of Trustees composed of the Council and Officers of the State Medical Society and up to ten elected non-medical persons. In addition each of the 54 component county societies may elect a representative who is considered a corporate member of the Board. Although the membership of the Board of Trustees numbers over 90, the Officers and Executive Committee constitute an efficient working body in governing the routine affairs of the Foundation. The Officers of the State Medical Society, the Officers of the Foundation, and certain elected trustees constitute the Executive Committee of the Board. A meeting of the entire Board is held at least annually. Officers are elected at that time. The Executive and other committees meet periodically throughout the year. The Foundation's organization insures continuing liaison at the county medical society level throughout Wisconsin and an integration with the governing body of the State Medical Society itself. Such an arrangement assures a personal and realistic approach to Foundation activities.

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Let These Guides Help You

The following guides and manuals have been prepared or obtained at the direction of the Council and/or commissions and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Public Relations Dept, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

- **Interprofessional Code (1977 Revision)**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices. (Also appears in this issue of WMJ)

- **Guide to the Service Corporation Law**

- **Communications Guide for Wisconsin Hospitals and Physicians**—Establishes a communications guide for Wisconsin hospitals and physicians to promote cooperation between the allied medical professions and those who report medical news. (Also appears in this issue of WMJ)

- **Comments on Fee Splitting Statute, Including Chapter 82, Laws of Wisconsin, 1973**—Governing physicians and others and authorizing employment of physicians by hospitals and others.

- **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

- **National Health Planning and Resources Act of 1974 (PL 93-641)**—Sets up a nationwide network of regional Health Services Areas and Health Systems Agencies.

- **Approved Program in Continuing Medical Education**—Explains the State Medical Society of Wisconsins accreditation program for continuing medical education in conjunction with the American Medical Association's Council on Medical Education.

- **School Vision Screening Program**

- **First Aid Chart**

- **Physician Guidelines: Blood-Alcohol Testing**—Includes a request/consent form for drawing blood. (Single copy 25¢ with order.)

- **School Health Examination**—A guide for physicians and school authorities in establishing a program of school health examinations. (Single copy $1.00 with order.)

- **Occupational Health Guide**—For medical and nursing personnel. A practical manual covering everything from "abnormal injuries" to "wounds," with every item suggesting steps to be taken, and providing space for specific instructions of the plant physician. Over 70 pages of instructional material, with all sections provided as separate sheets, punched to fit a ring book 10″ x 11½″. For handy reference order ring book, with full set of inserts, including anatomical charts. (Complete guide including ring binder: $6.45; complete guide without binder: $5.25—to accompany order.)

- **Guide to the Medical Management of Acute Mind-Altering Drug Reactions (1972)**—Outlines an approach to management of acute intoxication with stimulants and hallucinogens such as amphetamines, LSD and cannabis. Describes drugs, diagnosis and therapy. (Single copy $1 with order.)

- **Physician and Hospital Records: Retention and Inspection**—Explains the right of access to physician and hospital records concerning patient care, and includes the revised form, through statute amendment, of an *Interpretation* of Chapter 301, Laws of 1959. (Also appears in this issue of WMJ)

- **Legal Responsibilities of the Physician-Patient Relationship.**

- **Report of the Chiropractic Study Committee to the Governor's Health Planning and Policy Task Force**—Recommendations in this report were adopted by the Governor's Health Planning and Policy Task Force, October 23, 1972.

- **A Scientific Test of the Chiropractic Theory**—The first experimental study of the basis of the theory demonstrates that it is erroneous. Writen by Edmund S Crelin and reprinted by permission of *American Scientist*.

- **Legislative Guide 1977-79**—Prepared by the State Medical Society's Physicians Alliance Division to assist physicians throughout the state to become familiar with the political process and to serve as *the* reference book for the legislative contact program.

- **Physicians Opinion Survey**—Conducted in 1976 by the State Medical Society, this comprehensive survey was undertaken by the Physicians Alliance Division in an effort to assess the concerns and attitudes of the physicians of Wisconsin. Key objective was to take a barometer of physicians' opinions and attitudes, and assess them in direct relationship to the policy directions of the State Medical Society of Wisconsin, and act accordingly based upon the results.

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COUNCILOR DISTRICTS AND COUNCILORS

District	Councilor
1	John P Mullooly, MD, Milwaukee
	Paul G LaBissoniere, MD, Wauwatosa
	Carl S L Eisenberg, MD, Milwaukee
	Elizabeth A Steffen, MD, Racine
	Wayne J Boulanger, MD, Milwaukee
	Daniel K Schmidt, MD, Milwaukee
	John J Foley, MD, Menomonee Falls
	William A Nielsen, MD, West Bend
	Irwin J Bruhn, MD, Walworth
2	Blake E Waterhouse, MD, Madison
	Richard W Edwards, MD, Richland Center
	William P Crowley, MD, Madison
	Allen O Tuftee, MD, Beloit
3	Cornelius A Natoli, MD, LaCrosse
4	John J Kief, MD, Rhinelander
	Russell F Lewis, MD, Marshfield
5	John U Peters, MD, Fond du Lac
	Timothy T Flaherty, MD, Neenah
6	Antoine Barrette, MD, Peshtigo
	Walter F Smejkal, MD, Manitowoc
7	Paul S Haskins, MD, River Falls
8	Thomas J Doyle, MD, Superior

THE SOCIETY'S PLACEMENT SERVICE AIDS PHYSICIANS AND COMMUNITIES

ONE OF THE MANY FUNCTIONS of the State Medical Society of Wisconsin is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians. This activity is called Placement Service.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are also maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

A list of openings is sent to all physicians who contact Placement Service indicating that they desire to locate in Wisconsin or desire to relocate within the state. A list of physicians is sent to all communities who request assistance in obtaining a physician. The physicians contact the communities and the communities may contact the physicians. Physicians desiring associates may also request a listing of available physicians.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years; even medical students have requested location lists. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

Physicians and communities may also utilize the "Medical Yellow Pages" section of the *Wisconsin Medical Journal.* This is a classified advertising section which is available to members of the State Medical Society, other physicians, communities, clinics, hospitals and others at reasonable rates.

Physicians who have used the Placement Service have described it as one of the most effective in the United States. *Journal* advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, tel. 608/257-6781; and/or *Wisconsin Medical Journal,* Box 1109, Madison, Wis. 53701

Officers and Councilors 1977-1978

State Medical Society of Wisconsin

330 East Lakeside St (PO Box 1109), Madison, Wis 53701 • Tel 608/257-6781

OFFICERS OF THE SOCIETY

PRESIDENT (1977-1978)
Roy B Larsen, MD, 2000 Westwood Drive, Wausau 54401

PRESIDENT-ELECT (1977-1978)
Jules D Levin, MD, 1530 West Spruce Court, Milwaukee 53217

SECRETARY/GENERAL MANAGER
Earl R Thayer, 330 East Lakeside St, Madison 53701

TREASURER (1977-1978)
Eugene J Nordby, MD, 2704 Marshall Court, Madison 53705

SPEAKER (1977-1978)
Albert J Motzel Jr, MD, 1111 Delafield St, Waukesha 53186

VICE-SPEAKER (1977-1978)
Duane W Taebel, MD, 1836 South Ave, LaCrosse 54601

PAST PRESIDENT (1977-1978)
Charles J Picard, MD, 425 21st Ave East, Superior 54880

THE COUNCIL

CHAIRMAN
Paul S Haskins, MD, River Falls

VICE-CHAIRMAN
Richard W Edwards, MD, Richland Center

COUNCILORS (by districts*)

FIRST: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha Counties

John P Mullooly, MD (1976-1979)
411 E Mason, Milwaukee 53202

Paul G LaBissoniere, MD (1976-1979)
10425 W North St, Wauwatosa 53226

Wayne J Boulanger, MD (1975-1978)
324 E Wisconsin Ave, Milwaukee 53202

Daniel K Schmidt, MD (1975-1978)
720 E Wisconsin Ave, Milwaukee 53202

John J Foley, MD (1975-1978)
PO Box 427, Menomonee Falls 53051

William A Nielsen, MD (1975-1978)
PO Box 178, West Bend 53095

Irwin J Bruhn, MD (1975-1978)
Walworth 53184

Carl S L Eisenberg, MD (1977-1980)
3003 West Good Hope Rd
Milwaukee 53209

Elizabeth A Steffen, MD (1977-1978)
734 Lake Ave, Racine 53403

SECOND: Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Marquette, Richland, Rock, Sauk Counties

Blake E Waterhouse, MD (1976-1979)
30 S Henry St, Madison 53703

Richard W Edwards, MD (1976-1979)
1313 W Seminary St, Richland Center 53581

William P Crowley, MD (1976-1978)
20 S Park St, Madison 53715

Allen O Tuftee, MD (1976-1979)
1146 Grant St, Beloit 53511

THIRD: Buffalo, Crawford, Jackson, Juneau, LaCrosse, Monroe, Trempealeau, Vernon Counties

Cornelius A Natoli, MD (1977-1980)
2760 Hagen Road, LaCrosse 54601

FOURTH: Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, Wood Counties

John J Kief, MD (1977-1980)
1020 Kabel Ave, Rhinelander 54501

Russell F Lewis, MD (1977-1980
1000 N Oak Ave, Marshfield 54449

FIFTH: Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago Counties

John U Peters, MD (1976-1979)
505 E Division, Fond du Lac 54935

Timothy T Flaherty, MD (1977-1980)
547 E Wisconsin Ave, Neenah 54956

SIXTH: Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, Sheboygan Counties

Antoine Barrette, MD (1977-1980)
132 N Emery Ave, Peshtigo 54157

Walter F Smejkal, MD (1976-1979)
601 Reed Ave, Manitowoc 54220

SEVENTH: Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St Croix, Burnett, Washburn Counties

Paul S Haskins, MD (1977-1980)
409 Spruce St, River Falls 54022

EIGHTH: Ashland, Bayfield, Douglas, Iron, Sawyer Counties

Thomas J Doyle, MD (1975-1978)
1507 Tower Ave, Superior 54880

Past President *Picard*
President *Larsen*
Speaker *Motzel*
President-elect *Levin*
Vice-speaker *Taebel*

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

TERMS ENDING DEC 31, 1977

Gerald J Derus, MD (1976-1977)
5001 Monona Dr, Madison 53716

Henry F Twelmeyer, MD (1976-1977)
2500 N Mayfair Rd, Wauwatosa 53226

TERMS ENDING DEC 31, 1978

John E Dettmann, MD (1977-1978)
1751 Deckner Ave, Green Bay 54302

George E Collentine, Jr, MD (1977-1978)
2388 N Lake Dr, Milwaukee 53211

Delore Williams, MD (1977-1978)
8501 W Lincoln Ave, West Allis 53227

TERMS STARTING JAN 1, 1978

Gerald J Derus, MD (1978-1979)
5001 Monona Dr, Madison 53716

Henry F Twelmeyer, MD (1978-1979)
2500 N Mayfair Rd, Wauwatosa 53226

ALTERNATES TO THE AMA

TERMS ENDING DEC 31, 1977

John K Scott, MD (1976-1977)
1605 Monroe St, Madison 53711

Leo R Grinney, MD (1977)
209 8th St, Racine 53403

TERMS ENDING DEC 31, 1978

George A Behnke, MD (1977-1978)
1107 Riverside Drive, Kaukauna 54130

Harold J Kief, MD (1977-1978)
505 E Division St, Fond du Lac 54936

Patricia J Stuff, MD (1977-1978)
PO Box 522, Bonduel 54107

TERMS STARTING JAN 1, 1978

John K Scott, MD (1978-1979)
1605 Monroe St, Madison 53711

Leo R Grinney, MD (1978-1979)
209 8th St, Racine 53403 ■

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*Map indicating location of districts, opposite page.

Note: Officers, councilors, delegates, and members of Commissions and Committees are elected at the Annual Meeting (April 1977). Dates in parentheses indicate beginning and expiration of term of office.

AMA Delegates and Alternates' terms of office are on a calendar basis, although elected at the Annual Meeting. (Those elected at the 1977 Annual Meeting for terms beginning in 1978, as well as those whose terms did not expire, are shown below the current listing.)

Officers and Councilors: 1977-1978

STATE MEDICAL SOCIETY OF WISCONSIN

R B Lorsen, MD
President

C J Picord, MD
Past President

P S Hoskins, MD
Council Chairman
Councilor, Dist 7

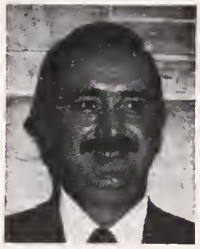
Jules D Levin, MD
President-elect

A J Matzel Jr, MD
Speaker

E J Nordby, MD
Treasurer

E R Thayer
Secretary

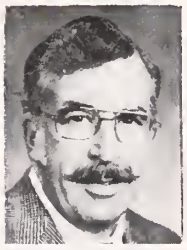
Duone W Toebel, MD
Vice-Speaker


R W Edwords, MD
Council V-Chairmon
Councilor, Dist 2

W J Baulonger, MD
Councilor, Dist 1

I J Bruhn, MD
Councilor, Dist 1

J J Foley, MD
Councilor, Dist 1


P G LaBissaniere, MD
Councilor, Dist 1

J P Mullooly, MD
Councilor, Dist 1

W A Nielsen, MD
Councilor, Dist 1

D K Schmidt, MD
Councilar, Dist 1

C S L Eisenberg, MD
Councilor, Dist 1

E A Steffen, MD
Councilor, Dist 1

W P Crawley, MD
Councilor, Dist 2

A O Tuftee, MD
Councilor, Dist 2

B E Waterhause, MD
Councilor, Dist 2

C A Natali, MD
Cauncilor, Dist 3

J J Kief, MD
Councilor, Dist 4

R F Lewis, MD
Councilor, Dist 4

T T Floherty, MD
Councilor, Dist 5

J U Peters, MD
Cauncilor, Dist 5

Antoine Barrette, MD
Councilor, Dist 6

W F Smejkol, MD
Cauncilor, Dist 6

T J Doyle, MD
Councilor, Dist 8

Commissions and Committees—1977-1978

State Medical Society of Wisconsin

330 East Lakeside St (Box 1109), Madison Wis 53701 • Tel 608/257-6781

COMMISSIONS

COMMISSION ON CONTINUING MEDICAL EDUCATION

This commission shall consist of nine appointed members and the deans of the two medical schools in Wisconsin, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commissions on Peer Review and Health Facilities and Services for purposes of implementing continuing medical education programs related to responsibilities and activities of these two commissions; and the scientific program of the annual meeting. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

George L Lucas, MD, Madison, 1978
Donald C Whitenack, MD, LaCrosse, 1978
John L Raschbacher, MD, Waukesha, 1978
Warren J Holtey, MD, Marshfield, 1979
Chairman
Bradley G Garber, MD, Osseo, 1979
William E Hein, MD, Green Bay, 1979
Martin Z Fruchtman, MD, Waukesha, 1980
Joseph C Darin, MD, Milwaukee, 1980
George A Berglund, MD, Milwaukee, 1980
Vice-chairman
Gerald A Kerrigan, MD, Dean, Medical College of Wisconsin
Lawrence G Crowley, MD, Dean, University of Wisconsin Medical School

COMMISSION ON GOVERNMENTAL AFFAIRS

This commission shall concern itself with all state and federal health legislation, its analysis and communication to the membership; preparing and securing state or federal health legislation for the best interests of the public, scientific medicine, and the medical profession; legislative representation and liaison, state and federal; informing the membership of the Society of important proposed legislation and encouraging members to be active individually in political affairs; liaison between the Society and executive and legislative branches of government; coordination of county legislative committees required by the Bylaws.

Membership of the Commission on Governmental Affairs shall include a representative from each of the specialty sections of the Society. These representatives shall be appointed by the specialty sections annually. Such appointments shall be subject to the approval by the Council. Representatives on the Commission from the specialty sections need not be counted for purposes of a quorum for a meeting of the Commission on Governmental Affairs, but shall have the right to vote.

Joseph M Lubitz, MD, Oconomowoc, 1978
Chairman
Thomas L Carter, MD, Madison 1978
Martin L Janssen, MD, Friendship, 1978
Thomas P Belson, MD, Waukesha, 1979
Theodore C Fox, MD, Antigo, 1979
J D Kabler, MD, Madison, 1979
Vice-chairman
Robert F Purtell, Jr, MD, Milwaukee 1980
Jack D Edson, MD, Eau Claire, 1980
Raymond C Zastrow, MD, Wauwatosa, 1980

The Commission also has a representative from each of the specialty sections of the Society.

The Commission also has a subcommittee —Committee on Federal Legislation—which is listed on page 79.

COMMISSION ON HEALTH FACILITIES AND SERVICES

This commission shall be concerned about inpatient, outpatient and ambulatory care facilities and services including standards; emergency and disaster care; comprehensive and regional health planning; physician manpower and training; licensing, certification and registration of physicians and other health care personnel; matters pertaining to medical staffs of health care institutions including the Joint Commission on Accreditation of Hospitals and its application in Wisconsin; distribution of medical services and matters affecting the health care delivery system; and relationships with allied health personnel.

Larry W Johnson, MD, Lancaster, 1978
John D Hart, MD, Shawano, 1978
Guenther Pohlmann, MD, Milwaukee, 1978
Edward Lennon, MD, Milwaukee, 1979
Bruce J Stoehr, MD, Green Bay, 1979
Dale V Moen, MD, Shell Lake, 1979
Marvin G Parker, MD, Racine, 1980
Donald R Korst, MD, Madison, 1980
Fredric L Hildebrand, MD, Neenah, 1980

COMMISSION ON PEER REVIEW

This commission may have up to twenty-five members. It shall initiate, explore, and bring to the attention of the Council suggested policies and programs relating to peer review in Wisconsin; serve as the advisory and coordinating body within the Society for the development of a statewide basis of medical peer review, including utilization review, appropriateness of care, services and fees, and quality assurance, and the establishment of local and/or district peer review committees; serve as the initial appellate body for peer and utilization review in the state to consider cases appealed from local committees involving the quality and utilization of medical care; function as the medical component for implementation of peer review under Wisconsin Health Care Review, Inc., and as the Society's advisory body on PSRO.

John B McAndrew, MD, Oshkosh, 1978
Lloyd R Cotts, MD, Rice Lake, 1978
Enzo Krahl, MD, Superior, 1978
Joseph B Grace, MD, Green Bay 1978
James M Huffer, MD, Madison, 1978
Addis Costello, MD, Milwaukee, 1978
John D Riesch, MD, Menomonee Falls, 1978
Ronald J Darling, MD, Waukesha, 1979
Richard W Edwards, MD, Richland Center, 1979
Arthur J Jacobsen, MD, Woodruff, 1979
Edwin W Hoeper, MD, Marshfield, 1979
Vice-chairman
Leo Grinney, MD, Racine, 1979
Erwin O Hirsch, MD, Milwaukee, 1979
Chairman
John Erbes, MD, Milwaukee, 1979
Rocco Latorraca, MD, Cudahy, 1980
Robert E Johnston, MD, Green Bay, 1980
Richard Logan, MD, Madison, 1980
Melvin F Huth, MD, Baraboo, 1980
Mark Lochner, MD, Waupaca, 1980
William D James, MD, Dousman, 1980
David Westgard, MD, LaCrosse, 1980

Chairman and vice-chairman of commissions and committees are elected at the first meeting following the Annual Meeting. The BLUE BOOK is prepared prior to most of these elections; therefore, some commissions and committees will not include these designations.

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Dallas, Texas 75229 Ph. (214) 243-4253

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COMMISSION ON MEDIATION AND PROFESSIONAL ETHICS

This commission shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, and when it deems necessary to recommend to the Council disciplinary or other action as appropriate. It shall also be concerned with matters of interprofessional conduct, including development of appropriate codes of interprofessional relations, and advise and consult with component societies on problems of ethics and discipline in concert with members of the Council whose responsibilities for this area are specified in the Bylaws.

Gerald C Kempthorne, MD, Spring Green, 1978
Chairman

G John Weir, Jr, MD, Marshfield, 1978

Brian T Coffey, MD, Racine, 1978
Vice-chairman

Bernhardt E Stein, MD, Madison, 1979
Owen E Larson, MD, Neenah, 1979
John Wear, Jr, MD, Madison, 1979
Charles E Koepp, MD, Marinette, 1980
Herman J Dick, MD, Sheboygan, 1980
Harry F Weisberg, MD, Milwaukee, 1980

COMMISSION ON PUBLIC INFORMATION

This commission shall be concerned about the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, develop effective media relations, and recruit and retain physician members of the Society and encourage their active participation in the affairs of the county and state societies and the American Medical Association.

Richard W Shropshire, MD, Madison, 1978
Robert M Senty, MD, Sheboygan, 1978
Wallace MacMullen, MD, Green Bay, 1978
Robert Feulner, MD, Waukesha, 1979
Herbert F Sandmire, MD, Green Bay, 1979
Charles Sorensen, MD, Wisconsin Rapids, 1979
Raymond G Welsch, MD, Kenosha, 1980
Joseph W Edgett, Jr, MD, LaCrosse, 1980
Mark J Popp, MD, Brookfield, 1980

PHYSICIANS ALLIANCE COMMISSION

This commission shall have 18 members consisting of one for each Councilor District, except that District 2 shall have two members and District 1 shall have seven members. In addition, the President of the State Medical Society, the Chairman of the Council, and Chairman of the Commission on Governmental Affairs will be ex officio members with vote. Nominations for membership on the commission shall be made by the Council Nominating Committee, but nominees shall be actively solicited from within each district by contact with the county medical societies and the medical staffs of hospitals. The commission shall be concerned with planning, organizing, and implementing appropriate programs to protect, promote, and achieve the socio-economic interests of the members of the State Medical Society of Wisconsin. It shall report to the Council at every regular meeting and annually to the House of Delegates, both as to its operations and policy recommendations.

Raymond R Watson, MD, Milwaukee, 1978
Robert B Jachowicz, MD, Hales Corners, 1978
Russell Quirk, MD, Racine, 1978
Frederick C Kriss, MD, Madison, 1978
Joseph C Diraimondo, MD, Manitowoc, 1978
Rudolph P Froeschle, MD, Waukesha, 1979

Kenneth M Viste, Jr, MD, Oshkosh, 1979
Chairman

Louis H Frase, MD, Eau Claire, 1979
Harry H Larson, MD, Ashland, 1979
Robert Kitzman, MD, Rhinelander, 1979
LaVern H Herman, MD, Waukesha, 1980
Paul A Jacobs, MD, Milwaukee, 1980
Charles E Pechous, Jr, MD, Kenosha, 1980

Jordon Frank, MD, Beloit, 1980
Vice-chairman

Charles N Ford, Jr, MD, LaCrosse

Roy B Larsen, MD, Wausau
President of State Medical Society

Paul S Haskins, MD, River Falls
Chairman of the Council

Joseph M Lubitz, MD, Oconomowoc
Chairman of Commission on Governmental Affairs

WISCONSIN MEDICAL JOURNAL

The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chairman and six additional members shall be responsible for all scientific, editorial, and business affairs of the Journal. An editorial director, serving as chairman of a group of no less than five editorial associates, shall be responsible for regularly providing items of editorial opinion for publication in the editorial pages of the Journal.

Victor S Falk, MD, Edgerton, 1978
Chairman and Medical Editor

Richard D Sautter, MD, Marshfield, 1978
Merlyn C F Lindert, MD, Milwaukee, 1978
Wayne J Boulanger, MD, Milwaukee, 1979
Harold H Scudamore, MD, Monroe, 1979
Melvin F Huth, MD, Baraboo, 1980
Garrett A Cooper, MD, Madison, 1980

COMMITTEES

COMMITTEE ON AGING AND EXTENDED CARE FACILITIES

This committee shall be concerned about the process of aging and means to achieve the best possible health care for the aged, including nursing home care.

Thomas R Leicht, MD, Green Bay, 1978
Thomas F Nikolai, MD, Marshfield, 1978
Nicholas L Owen, MD, Milwaukee, 1978
Elston L Belknap, Jr, MD, Madison, 1979
Donald J Heyrman, MD, Menomonee Falls, 1979
William B Potos, MD, Cudahy, 1979
Joseph Springberg, MD, Beloit, 1980
Frederick W Blancke, MD, Madison, 1980
Gertrude Howe, MD, Fish Creek, 1980

COMMITTEE ON ALCOHOLISM AND OTHER DRUG ABUSE

This committee shall be concerned about prevention, treatment, and rehabilitation for persons affected by alcoholism and any other type of drug abuse.

Ronald L Harms, MD, Shawano, 1978
Fordyce A Ross, MD, Milwaukee, 1978
Warren H Williamson, MD, Racine, 1978
Alan E Reed, Jr, MD, Wauwatosa, 1979
Marwood E Wegner, MD, St Croix Falls, 1979
Duane Taebel, MD, LaCrosse, 1979
Darold A Treffert, MD, Fond du Lac, 1980
Eugene J Kinder, MD, Spring Green, 1980
Edward C Schmidt, MD, Milwaukee, 1980

COMMITTEE ON CANCER

This committee shall be concerned about the cause, diagnosis, prevention, and alleviation of human cancer.

John D Hurley, MD, Milwaukee, 1978
Vice-chairman

Robert E Carlovsky, MD, Fond du Lac, 1978
John J Smalley, Jr, MD, LaCrosse, 1978

John K Scott, MD, Madison, 1979
Chairman

Donald A Jeffries, MD, Shawano, 1979
Marcia Richards, MD, Milwaukee, 1979
Glenn A Smiley, MD, Delavan, 1980
Ralph C Frank, MD, Eau Claire, 1980
James J Tydrich, MD, Richland Center, 1980

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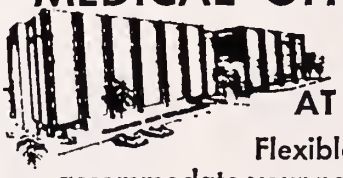

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COMMITTEE ON MATERNAL AND CHILD HEALTH

This committee shall be concerned about all aspects of health in pregnancy, childbirth, and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

Richard C Brown, MD, Eau Claire, 1978
Walter R Schwartz, MD, Wauwatosa, 1978
Raymond E Burrill, MD, Marshfield, 1978
Kilian H Meyer, MD, Richland Center, 1979
Edward Buerger, MD, Waukesha, 1979
Curtis R Weatherhogg, MD, Madison, 1979
David V Foley, MD, Milwaukee, 1980
Elizabeth Steffen, MD, Racine, 1980
James C Tankersley, MD, LaCrosse, 1980

COMMITTEE ON MEDICINE AND RELIGION

This committee shall be concerned about the medical-spiritual values of health care and the development of closer relationships between physicians and clergy to permit discussion of common problems in the total treatment and care of patients.

Richard W Shropshire, MD, Madison, 1978
Frank J Cerny, MD, Fond du Lac, 1978
Donald F Cohill, MD, Racine, 1978
John O Simenstad, MD, Osceola, 1979
Chairman
John S Harris, MD, Appleton, 1979
John P Mullooly, MD, Milwaukee, 1979
Maxwell Weingarten, MD, Milwaukee, 1980
John K Scott, MD, Madison, 1980
E Basil Jackson, MD, Milwaukee, 1980

COMMITTEE ON NERVOUS AND MENTAL DISEASES

This committee shall be concerned with all aspects of mental health as an equal part of the patient's total wellbeing.

Henry Veit, MD, Milwaukee, 1978
Chairman
Guy G Giffen, MD, Eau Claire, 1978
George F Meisinger, MD, Fond du Lac, 1978
David P Donarski, MD, Green Bay, 1979
William H Heywood, MD, Marshfield, 1979
Gerald C Kempthorne, MD, Spring Green, 1979
Francis M Forster, MD, Madison, 1980
Theodore J Nereim, MD, Mount Horeb, 1980
Vice-chairman
Edward D Meyer, MD, Oshkosh, 1980

COMMITTEE ON OCCUPATIONAL HEALTH

This committee shall be concerned about the health and safety of persons in relation to their occupation. This shall include matters concerning Worker's Compensation.

Carl Zenz, MD, West Allis, 1978
Chairman
Kenneth R Peters, MD, Menomonee Falls, 1978
Donald M Rowe, MD, Kohler, 1978
Charles W Fishburn, MD, New Berlin, 1979
Vice-chairman
William A Nielsen, MD, West Bend, 1979
William C Curtis, MD, Milwaukee, 1979
John T Bruton, MD, Racine, 1980
John W Faber, MD, Neenah, 1980
Louis Olsman, MD, Kenosha, 1980

COMMITTEE ON RURAL HEALTH

This committee shall be concerned with the special problems related to assuring adequate medical and health care for those who live in rural areas.

Robert G Hansel, MD, Baraboo, 1978
John J Beck, MD, Sturgeon Bay, 1978
Gustave A Landmann, Jr, MD, Tomah, 1978
George H Handy, MD, Madison, 1979
Walther W Meyer, MD, Medford, 1979
Robert A Starr, MD, Viroqua, 1979
Edward J Stack, MD, Superior, 1980
Timothy A Correll, MD, Dodgeville, 1980
Burton K Smith, MD, Wausau, 1980

COMMITTEE ON SCHOOL HEALTH

This committee shall be concerned about protecting and improving the health of those attending the public or private schools of this state, including matters related to athletics.

Frederic W Reichardt, MD, Stevens Point, 1978
George H Handy, MD, Madison, 1978
Horace K Tenney, III, MD, Madison, 1978
James C H Russell, MD, Ft Atkinson, 1979
Vincent Savaglio, MD, Kenosha, 1979
Darrell Witt, MD, Wausau, 1979
William T Brodhead, MD, Madison, 1980
Frank Walker, MD, Brookfield, 1980
Lawrence K Siegel, MD, Waukesha, 1980

COMMITTEE ON SAFE TRANSPORTATION

This committee shall be concerned about the health and safety of all who may be affected by the use of vehicles of transportation on land, water, or in the air.

James L Weygandt, MD, Sheboygan Falls, 1978
Chairman
Fred Bunkfeldt, Jr, MD, Milwaukee, 1978
Glenn C Hillery, MD, Lancaster, 1978
Eugene Eckstam, MD, Monroe, 1979
Ralph F Hudson, MD, Eau Claire, 1979
Walter F Smejkal, MD, Manitowoc, 1979
Clarence E Moore, MD, Fond du Lac, 1980
James M Huffer, MD, Madison, 1980
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CAN YOU PRACTICE WITHOUT A LICENSE?

The practice of medicine and surgery within this state requires a license. Even physicians just finishing their military service, or moving to Wisconsin from another state, *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to disciplinary action as well as criminal penalties.

Temporary licenses may be granted under special circumstances by the State Medical Examining Board. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practice in this state.

NARCOTICS

Annual Registration

A physician who desires to dispense, administer, or prescribe any controlled drug substance is required to have a Drug Enforcement Administration number (DEA no.). The Regional Office of the DEA in Chicago has informed the State Medical Society that it will notify all physicians when they must renew their number and send in the $5.00 application fee.

Change of Residence

If you move, or change your place or places of business, you must notify the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC, 20005.

In Case of Death

The Regional Director, Drug Enforcement Administration, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, P O Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Preprinted Prescription Blanks

The Justice Department, Drug Enforcement Administration, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

County Medical Societies

Presidents, Secretaries and Meeting Schedules

County	*President*	*Secretary*	*Meeting*
Ashland—Bayfield—Iron	Kenneth A Morrow, Rte 1, Box 61A, Ashland 54806	Charles R Longstreth, PO Box 49, Ashland 54806	On-call
Barron—Washburn—Burnett	James F Maser, 1020 Lake St, Rice Lake 54868	Donald E Riemer, PO Box 127, Cumberland 54829	Second Tuesday of month
Brown	John M Mills, 923 Eliza St, Green Bay 54301 *Treasurer:* John M Guthrie, 1751 Deckner Ave, Green Bay 54302	James R Mattson, 501 S Military Ave, Green Bay 54301 *Executive Secretary:* Ms Bernice Mangless, 501 S Military Ave, Green Bay 54301	Second Thursday of month
Calumet	Kenneth R Humke, 26 School St, Chilton 53014	James C Pinney, 507-C W Main St, Hilbert 54129	On-call
Chippewa	Mahmoud S Taman, 411 E Wisconsin Ave, Chippewa Falls 54729	Fe Q Gonzaga, 133 W Central St, Chippewa Falls 54729	First Tuesday of month
Clark	James Connolly, 204 W Prospect Ave, Thorp 54771	Ana C Capati, 305 Sunset Pl, Neillsville 54456	On-call
Columbia—Marquette—Adams	Rahmatollah Simani, Friendship 53934 *Executive Secretary:* Mrs Elayne Hanson, 912 Cass St, Portage 53901	Fredrick H Bronson, RR #2, Fox Glen Rd, Portage 53901	On-call
Crawford	Thomas F Farrell, 610 E Taylor St, Prairie du Chien 53821	Michael S Garrity, 610 E Taylor St, Prairie du Chien 53821	Third Wednesday of month
Dane	Carl B Weston, 30 S Henry St, Madison 53703	George F Roggensack, 1014 Hillside Ave, Madison 53705	First Tuesday of month
Dodge	Curtis W Bush, 1200 N Center St, Beaver Dam 53916	Ki Jun Whang, 130 Warren St, Beaver Dam 53916	Last Thursday of month
Door—Kewaunee	William Faller, 330 S 16th Pl, Sturgeon Bay 54235		Fourth Tuesday of month, Sept thru May
Douglas	Robert L Sellers, 318-21st Ave, E, Superior 54880	William D Berg, 620 N 23rd St, Superior 54880	First Wednesday of month
Eau Claire—Dunn—Pepin	Richard S Ostenson, 310 Chestnut St, Eau Claire 54701	Jack D Edson, PO Box 224, Eau Claire 54701	Fourth Monday of month
Fond du Lac	Kenneth A Stormo, 430 E Division St, Fond du Lac 54935 *Treasurer:* Harry J Zemel, 430 E Division St, Fond du Lac 54935	Jacob M Gerend, 827 Ellen Lane, Fond du Lac 54935	Fourth Thursday of month
Forest	E F Castaldo, Laona 54541	Burton S Rathert, 101 W Washington, Crandon 54520	On-call
Grant	Mildred Stone, 507 East Webster, Cuba City 53807	Harold W Carey, 257 Madison St, Lancaster 53813	On-call
Green	V K Nair, 1515-10th St, Monroe 53566	Fernando S Santiago, 2709 Sixth St, Monroe 53566	Third Monday of month
Green Lake—Waushara	Robert L Demke, 203 North Main, Westfield 53964	Lynn J Seward, 147 North State St, Berlin 54923	On-call
Iowa	Young I Kim, 109 West Fountain St, Dodgeville 53533	Harald P Breier, 207 Main St, Montfort 53569	Second Tuesday of month, recess for summer
Jefferson	Walter D Moritz, Rte 4, Box 239, Fort Atkinson 53538	Douglas D Wilson, 123 Hospital Dr, Watertown 53094	Third Thursday of month
Juneau	Clayton L Weston, 116 S Adams St, New Lisbon 53950	Jack Strong, 143 Division, Mauston 53948	On-call
Kenosha	Roman Bilak, 6032-40th Ave, Kenosha 53140 *Executive Secretary:* Mr Mark J Gorman, 3916 67th St, Kenosha 53140	Vincent P Savaglio, 6530 Sheridan Rd, Kenosha 53140	First Thursday of month

continued next page

County	*President*	*Secretary*	*Meeting*
LaCrosse	Eugene J Valentini, 709 S 10th St, LaCrosse 54601	Stephen B Webster, 1836 South Ave, LaCrosse 54601	Third Monday of month
Lafayette	Lyle L Olson, 517 Park Pl, Darlington 53530	Norbert A McGreane, 112 E Ann St, Darlington 53530	On-call
Langlade	John E McKenna, 837 Clermont St, Antigo 54409	A N Chatterjee, 323 Sunset Dr, Antigo 54409	Second Tuesday of month
Lincoln	Jerome S Mayersak, PO Box 232, Merrill 54452	T O Vechinski, 717 Tee Lane Dr, Merrill 54452	Fourth Tuesday of month, Sept thru May
Manitowoc	Richard R Whereatt, 600 York, Manitowoc 54220	Edward J Barylak, PO Box 279, Manitowoc 54220	Third Thursday of month
Marathon	Francis C Johnson, 400 E Thomas St, Wausau 54401	G H Brister, Wausau Hospital North, Maple Hill, Wausau 54401	Second Tuesday of month
Marinette—Florence	John E Kraus, 1510 Main St, Marinette 54143	James A Boren, 1510 Main St, Marinette 54143	Third Wednesday of month
Milwaukee	Joseph C Darin, 8700 W Wisconsin Ave, Milwaukee 53226 *Executive Director:* Mr Michael McManus, 411 E Mason St, Milwaukee 53202	Sidney K Wynn, 606 W Wisconsin Ave, Milwaukee 53203	Dec (Annual) Feb, June & Oct
Monroe	Jack D Brown, 202 South K St, Sparta 54656	Gustave A Landmann, PO Box 552, Tomah 54660	Second Monday of month
Oconto	Clyde E Siefert, 164 N Main St, Oconto Falls 54154	Kim Y Chung, 1113 N Main St, Oconto 54153	Third Tuesday of month
Oneida—Vilas	Paul W Grotenhuis, Rte #1, Rhinelander 54501	Leo G Norden, 1020 Kabel Ave, Rhinelander 54501	On-call
Outagamie	Joseph B Weissler, 610 E Longview, Appleton 54911	Charles F Dungar, 506 E Longview, Appleton 54911	Third Thursday of month
Ozaukee	Henry J Katz, PO Box 126, Cedarburg 53012	Robert Henkle, 100 W Monroe St, Port Washington 53074	Fourth Thursday of month
Pierce—St Croix	James R Beix, 409 Spruce St, River Falls 54022	John May, Baldwin 54002	Third Tuesday of month
Polk	Mark E Boyken, 104 Adams St, South, St Croix Falls 54024	Arnold S Potek, Osceola 54020	Third Thursday of month
Portage	Clarence A Klasinski, 529 Division St, Stevens Point 54481	James D Miller, 950 College Ave, Stevens Point 54481	
Price—Taylor	Vladimir Uhri, 101 N Gibson Ave, Medford 54451	Walther W Meyer, 101 N Gibson Ave, Medford 54451	
Racine	Jerome J Veranth, 5200 Washington Ave, Racine 53406 *Treasurer:* Victoriano A Baylon, 717-15th St, Racine 53403	Karl H Kolmeier, 3801 Monarch Dr, Racine 53406 *Executive Secretary:* Mr Gilbert J Berthelsen, PO Box 592, Racine 53403	Third Thursday of month
Richland	Julius H Kelertas, 1313 W Seminary St, Richland Center 53581	L M Pippin, 1313 W Seminary St, Richland Center 53581	First Thursday of month
Rock	Rocco J Vitacca, 2000 E Racine, Janesville 53545	Paul F Frechette, 100 E Milwaukee St, Janesville 53545	On-call
Rusk	Ralph P Bennett, Ladysmith 54848	Joseph E Murphy, 403 E Miner St, Ladysmith 54848	Second Monday of month
Sauk	Melvin F Huth, 203 Fourth St, Baraboo 53913	Donald W Vangor, 703-14th St, Baraboo 53913	Second Tuesday of month
Sawyer	Lloyd M Baertsch, Rte #6, Box 700, Hayward 54843	Paul Strapon III, Rte #6, Box 700, Hayward 54843	
Shawano	Franklyn T Bergmann, 610 W Green Bay St, Shawano 54166	A J Sebesta, PO Box 311, Shawano 54166	Fourth Monday of month

County	President	Secretary	Meeting
Sheboygan	Henry J Winsauer, 1226 N 8th St, Sheboygan 53081	Herman J Dick, 2629 N 7th St, Sheboygan 53081	Third Thursday of month
Trempealeau—Jackson—Buffalo	Steven E Schaefer, 610 W Adams St, Black River Falls 54615	James J Dickman, II, 610 W Adams St, Black River Falls 54615	On-call
Vernon	P T Bland, 100 Melby St, Westby 54667	DeVerne W Vig, 125 W Jefferson, Viroqua 54665	On-call
Walworth	Daniel R Hansen, Rte #1, Walworth 53181	Menandro Tavera, Jr, Rte #4, Box 126, Lake Geneva 53147	Third Thursday of month
Washington	Paul R Rice, 210 Paradise Dr, West Bend 53095	James F Baumgartner, PO Box 178, West Bend 53095	Fourth Thursday of month, Sept thru May
Waukesha	Thomas A Hofbauer, PO Box 427, Menomonee Falls 53051 *Treasurer*: John S Blackwood, 17050 W North Ave, Brookfield 53005	Michael McCormick, 102 East Main St, Waukesha 53186 *Executive Secretary:* Mr Robert Herzog, 850 N Elm Grove Rd, Elm Grove 53122	First Wednesday of month
Waupaca	Terry L Hankey, 710 Riverside Dr, Waupaca 54981	Jerry R Salan, 710 Riverside Dr, Waupaca 54981	Second or third Thursday of month
Winnebago	Robert F Douglas, 1209 S Commercial St, Neenah 54956	Glenn E Gustafson, 222 Washington St, Menasha 54952	First Thursday of month
Wood	Richard H Ulmer, 1000 N Oak Ave, Marshfield 54449	James L Struthers, 1000 N Oak Ave, Marshfield 54449	Last Thursday of month ■

All officers above are MDs unless Mr or Mrs is indicated.

Members attention! Update records

The SMS Membership Department has an ongoing program for keeping members' records accurate and current. But occasionally information fails to get recorded in the members' files, or additional information is needed to meet current demands.

The Membership Department and the *Wisconsin Medical Journal* are verifying members' home and office addresses (and mailing address), their primary and secondary specialties, and whether certified and in what specialty.

ALL MEMBERS ARE REQUESTED to complete the form below and return promptly to the Membership Dept. This information is most important to physicians to assure proper listing. ■

TO: SMS Membership Department, Box 1109, Madison, Wis 53701

I submit the following information for your records:

NAME (Please print or type) _____ NAME (Please print or type) _____

HOME Street Address _____ OFFICE Street Address _____

CITY _____ ZIP CODE ☐ CITY _____ ZIP CODE ☐

Please indicate your mailing address for Society communications by checking appropriate box above.

PRIMARY Specialty _____ SECONDARY Specialty _____

☐ CERTIFIED in _____ (Specialty) DATE _____

MEMBER OF _____ COUNTY MEDICAL SOCIETY

OFFICERS OF SPECIALTY SECTIONS OF THE STATE MEDICAL SOCIETY

June 10, 1977

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Terms of office for Sections generally coincide with the State Medical Society's Annual Meetings or the Specialty Society Annual Meetings, and in most instances the President of the Specialty Society is named Chairman of the SMS Specialty Section.

STATE MEDICAL SOCIETY OF WISCONSIN AUXILIARY
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Vice President: Mrs Duane Taebel, 2290 Wedgewood Dr, East, LaCrosse 54601
Recording Secretary: Mrs Frederick Klaas, 371 South Maple St, East Ellsworth 54010
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Immediate Past President: Mrs Bernard S Schaeffer, 6220 North Santa Monica Blvd, Milwaukee 53217

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Historian: Mrs C Malcolm Scott, 11 St Alban's Rd, Superior 54880

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West-Central: Mrs Carl W Manz, 4442 Meadow Lane, Eau Claire 54701
Northeast: Mrs Daniel W Shea, 1336 Ridgeway Blvd, De Pere 54115
Northwest: Mrs Robert Kundel, Lakeview Dr, Rice Lake 54868
Southeast: Mrs Nazario Cruz, 7317 Second Ave, Kenosha 53140
Southwest: Mrs Sigurd E Sivertson, 305 Blue Ridge Parkway, Madison 53705

EXECUTIVE SECRETARY

Mrs LaVerne Bartel, 330 Lakeside St, Madison 53715 ■

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

WISCONSIN PROFESSIONAL REVIEW ORGANIZATION (WisPRO)

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†WALTER F SMEJKAL, MD, PO Box 279, Manitowoc 54220
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*KENNETH VAN BREE, Admin, Divine Savior Hospital, 1015 W Pleasant St, Portage 53901
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FRED B RIEGEL, MD, 208 Adams St, South, St Croix Falls 54024
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EDWIN W HOEPER, MD, 1000 N Oak, Marshfield 54449
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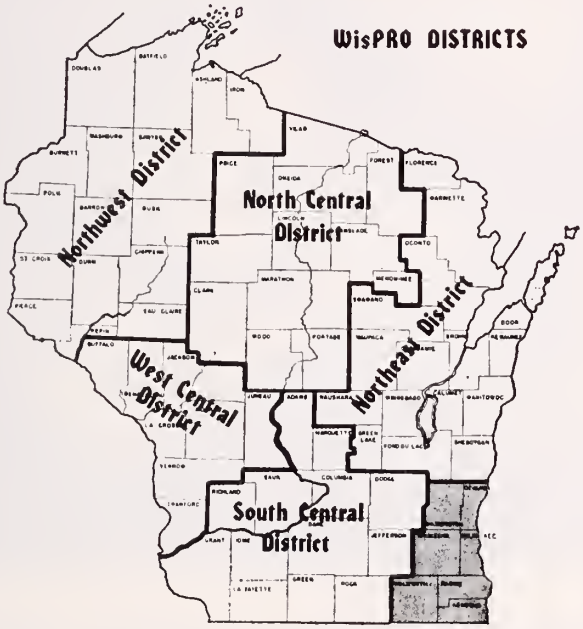

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2	Dane County Medical Society Insurance Advisory Committee
2	Dane County Medical Society Public Health Advisory Committee
3	Dane County Medical Society Board of Trustees
3	Title 19 Provider Agreement
5	Task Force on Health Screening and Immunization
6	Joint Practice Committee
11	SMS Commission on Peer Review
11	SMS Commission on Governmental Affairs
13	Executive Committee of SMS Council
16	Dane County HMP Committee
19	Board of Directors, Wisconsin Council of Professions
25	SMS Commission on Public and Professional Affairs
26	Task Force on Health Screening and Immunization
27	Scientific Program Planning, 1978 Annual Meeting
28	SMS Committee on Nervous and Mental Diseases

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

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Planning **266-7295**
- Staffing of Health Policy Council and its committees
- Development of State Comprehensive Health Plan
- Liaison with Health Systems Agencies and review of their plans and budgets
- Coordination of categorical health planning process
- Review of categorical health plans
- Liaison with agencies (public and private) that implement the State Health Plan
- Development of emergency medical services systems

Needs Review **266-7384**
- Review of 1122 capital expenditures
- Certificate of Need
- Service licensure
- Development of health facilities plan
- Review of categorical grants appeal

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- Oversight of the hospital and rate review process
- Administration of the Medical Assistance Program
- Promotion of plans for prepayment of comprehensive health services
- Liaison with Office of the Insurance Commissioner

Quality Compliance **266-8847**
- Title 18 and Title 19 certification
- Hospital and nursing home standard setting and enforcement
- Patient care evaluation
- Construction and plan review
- Development of facilities standards
- Laboratory certification

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Prevention **266-1251**
- Development and promotion of prevention programs
- Participation in preventive efforts within and outside the Department of Health and Social Services
- Promotion of research into major causes of illness and death and sponsorship of demonstration projects designed to reduce and eliminate root causes
- Health education for the public

Community Health **266-2661**
- Public health nursing
- Public health nutrition
- Dental health
- Maternal and child health
- Family planning
- Communicable diseases
- Standard epidemiology
- Chronic diseases
- Early and periodic screening, diagnosis and treatment (EPSDT) for children and other screening activities
- Immunization activities

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- Recruitment and staffing of health care positions in the institutions

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- Platting of unsewered subdivisions
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- Plumbing and fire protection services
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The Medical Care System Under National Health Insurance

Four Models That Might Work and Their Prospects

Walter McClure, PhD
Minneapolis, Minnesota

Walter McClure, PhD

DOCTOR MC CLURE is Director of Health Policy and Planning, InterStudy, a private health research group with headquarters in Excelsior, a Minneapolis suburb. He is one of America's outstanding experts on health-care costs, and government regulation of the medical profession and how physicians should respond. He is extremely influential in helping shape national health policy in this country. This influence was put into sharp focus only days after he addressed Wisconsin physicians at a socioeconomic luncheon during the State Medical Society's Annual Meeting, April 14-16, in Milwaukee, when President Carter addressed the nation to explain his first major proposals for containing health-care costs, placing national health insurance on a lower priority. The following comments are a summary of a larger report, of the same name, available from InterStudy, from which Doctor McClure based his presentation to Wisconsin physicians.

IT APPEARS that the American medical care system will require significant change under any foreseeable form of national health insurance (NHI). Indeed, the medical care system is so central to every issue now pressuring government to intervene in health care, that significant change appears unavoidable even in the absence of NHI. Therefore in asking what kind of NHI we want, Americans must begin asking what kind of future medical care system we want: they are the same question. This paper examines the forces compelling change and the major options open to us. The principal points are summarized below:

—Americans increasingly believe that medical care use should be determined not by income and personal circumstance but by some standard of need. Medicare and Medicaid and the growing interest in NHI are expressions of this belief. The dilemma is that we already know how to practice a style of medicine in the United States which, if extended equally to all, would be far more expensive than this nation would or should pay.

—The ability of American medicine and technology to elaborate this style is almost endless: the medical care system can legitimately absorb every dollar society will make available to it. Already this costly elaboration is occurring under Medicare, Medicaid and comprehensive private insurance to such an extent that government has felt compelled to intervene more and more strongly in the medical care system. Despite this intervention, medical care expenditures have risen more than 300% in the last ten years with little detectable improvement in the nation's health.

—This cost escalation is unlikely to abate. It is deeply rooted in the structure and incentives of the present medical care system and its financing. Considering that present health insurance artifically lowers the price to the consumer and provides a virtual blank check to the medical care system, which has every professional, financial, legal and ethical incentive to do more, it seems doubtful that costs can be acceptably contained short of significant change in the present system.

(As one example, in the next few years the United States could spend $20 billion on just one new procedure, coronary bypass surgery, alone. If one had $20 billion to spend on the health and well-being of the United States, would he spend it on a single procedure, particularly on one whose range of efficacy is not yet established? Would he even spend it on medical care alone, given that non-medical interventions—nutrition, environment, safety—have equal or greater impact on health? The point is that under the present system there is no choice: present health insurance commits us to buy whatever the medical care system chooses to do. This example can be endlessly multiplied.)

This analysis is part of the work carried out under a Health Services Research Center grant from the National Center for Health Services Research, Department of Health, Education, and Welfare (Grant No HS 00471-06). It was originally presented to the Panel on National Health Insurance, American Political Science Association, San Francisco, California, September 2, 1975. The larger article has been published in *Journal of Health Politics, Policy and Law*, Spring 1976.

—Thus health care is no longer a benign issue. Medical cost escalation is already placing severe strain on public and private budgets, increasingly impinging on our ability to finance other equally important national priorities. Should NHI force us to overspend for medical care, the health and well-being of the nation could actually be reduced. Eventually, the nation will be forced to do everything and anything necessary to contain medical costs.

—Present research and experience suggest three basic approaches that might contain costs: (1) increased consumer cost-sharing (higher deductibles and coinsurance, but with some maximum limit on what the consumer must pay) to make consumers more cost-conscious; (2) more prepaid alternative delivery systems (such as HMOs, etc.) which strongly alter provider incentives; and (3) extremely strong public utility regulation (most likely requiring the power to fix total expenditures in advance). An effective NHI program will combine one or more of these approaches. (But whatever combination of approaches is chosen, it must be built into NHI as a central feature; effective cost containment is too complex to be tacked on.)

—Each of the three approaches above exerts significant but different changes in the medical care system and its financing. But presently there is little awareness or consensus for change of this magnitude by either the public or providers. Consequently effective cost containment strategies will be politically long and difficult to implement, whereas ineffectual strategies will be easy (and very expensive) to fall into.

—To learn what works and to build consensus, public debate and incremental action on some consistent combination of the three potentially effective approaches should begin now, well in advance of NHI. The debate should focus on what future medical care system we want and in which direction proposed incremental actions are likely to lead us. Immediate incremental actions should be designed to learn more about all three approaches in mutually consistent ways which do not foreclose the available options. Such actions might include making existing cost-sharing more simple, more strongly encouraging alternative delivery systems, and focusing on regulation presaging an eventual "lid" on total expenditures.

FINDINGS AND CONCLUSIONS

A. The Problem

National health insurance may seriously aggravate medical care cost escalation and maldistribution. Even without NHI, medical cost escalation makes government action virtually inescapable.

1. As we learned from Medicare and Medicaid and the continuing spread of comprehensive private health insurance, present health insurance—whether public or private—is one of the principal causes of serious cost escalation.

Present health insurance artificially lowers the price to the consumer, gives a blank check to the provider, and leaves payment in the hands of a weak third party, the insuror, in no position to control either the use or cost of services. As a result, normal market mechanisms for cost constraint and efficiency are destroyed.

2. The other principal cause of cost escalation is the nature of medical care and the structure and incentives in the medical care system itself. The medical care system can legitimately absorb every dollar society will make available to it, and has every incentive to do so.

The style and standards of medical care are indefinitely expansible. By more and more elaborate diagnostic tests and therapeutic procedures, providers can always try to provide greater safety margins for treatable patients and try to treat more and more hopeless cases. Technology is continually expanding these possibilities. Moreover, the professional and financial incentives on providers in the present medical care system are powerfully skewed toward high cost, highly technological care. Professional challenge, reputation and income all increase with increasing specialization and more elaborate levels of care, giving rise to a kind of medical Parkinson's law: standards of practice rise to absorb the dollars available.

3. This combination of factors—health insurance removing the cost constraint from providers with powerful incentives for high cost care*—has produced a large, poorly distributed, inefficient medical care system with chronic cost escalation out of all proportion to any real or expected gains in health.

The cost escalation is predominantly demand-pull rather than cost-push. Costs do not push up prices; rather, insurance allows prices to be raised and providers put the dollars into higher cost activities. Contrary to popular expectation, aside from certain underserved subgroups there is little indication that more medical care will make measurable inprovement in the nation's health. Overall we appear to be beyond the point of diminishing marginal returns, where very large expenditures are needed to make even small gains for a few additional people. Improvement in health levels is more likely from improvement in nutrition, lifestyle and environment than from further investments in medical care.

4. Even without NHI, medical cost escalation is now so chronic and severe, its pressure on public and private budgets so great, that government action appears unavoidable; NIH will hasten such action.

In just ten years, medical expenditures have risen from 5.9% to 8.3% of GNP. So drastic a rate of cost escalation in so large an industry (which NHI would compound) not only constitutes significant inflationary pressure on the economy generally, but places extreme pressure on public budgets, which pay 40% of the bill. Just the annual increase in Medicare and Medicaid alone—$5 billion dollars and growing—will shortly exceed the cost of all other HEW health programs combined, increasingly impinging on our ability to finance other equally important national priorities. Even if some combination of public and private financing sources for NHI could be found today, at current rates of medical cost escalation we must be prepared to see the burden on those sources double in less than eight years. Thus without effective action, the medical care system, especially under NHI, threatens to become a vast vacuum cleaner, sucking up uncontrollable amounts of GNP and scare tax dollars for medical care.

B. Basic Options

It is doubtful that medical costs can be acceptably contained short of significant change in the present medical care system and its financing. Any effective cost

*It should be emphasized that the problem is structural, not conspiratorial. When someone else pays, providers try to do too much and patients want the best, including comfort and convenience, regardless of cost or potential effectiveness. The system is therefore misbehaving exactly the way society rewards it to misbehave.

containment strategy must consider what kind of future medical care system Americans want.

1. Cost escalation will not yield to quick band-aid solutions. Effective strategies must intervene and alter the deeply rooted incentives in the present system of medical care and health insurance described above.

We already know how to practice a style of medicine in this country which, if extended equally to all, would cost more than the nation would or should pay. We shall have to actively discourage aggressive, elaborate (high) styles of practice, and encourage equally effective but more conservative and efficient (low) styles. High style care is not necessarily bad or unnecessary; indications for medical intervention are so imprecise that acceptable styles of practice can vary 100% in per capita utilization. It is simply cost ineffective, i.e., we accomplish more health spending our money in other ways. Therefore, high style will not be curtailed by controls simply aimed at bad or unnecessary care, no matter how powerful. It will be curtailed by strategies altering or countering incentives in the present system supporting high styles.

2. There are three major options which present research and experience suggest might contain cost. Each has quite different impacts on the present system of medical care and health insurance. All will be politically difficult to implement.

The three options correspond to the three parties with power to control cost and use of services, who could replace the weak third party payer: respectively (1) the consumer, (2) the provider, and (3) the government. The first two approaches anticipate less government involvement ("consumer market oriented"); the third anticipates increased government involvement ("public utility oriented"). An effective cost strategy will combine one or more of these options.

—*Consumer cost-sharing*: Presently if the consumer is fully insured, he has no incentive to be an efficient user of care. This approach would use large coinsurance and deductibles to induce the consumer to use care more prudently. (Financial protection can still be assured by limiting the consumer's cost-share to some maximum amount. Bias against the poor can be avoided if the cost-share is income-related). This approach entails the least change in the medical care system, but other controls will be necessary for catastrophic care above the consumer's maximum cost-share limit. However, cost sharing of the magnitude necessary to work effectively involves taking away existing benefits, which is extremely difficult politically.

—*Provider Incentives*: Providers are presently rewarded for cost-raising behavior. This approach would reorganize the private medical care system so that it has improved structure and incentives for cost-effective performance; the encouragement of HMOs and other prepaid alternative delivery systems are examples. However, considerable private initiative will be needed to create sufficient change to influence the behavior of the entire medical care system. Encouraging the necessary motivation and acceptance will be difficult. (Incentive reimbursement of fee-for-service providers may also be possible, but this verges more toward the regulatory approach below since it must be compulsory to work.)

—*Public Utility Regulation*: Public cost controls are presently limited to Medicare and Medicaid, which simply squeezes the old and the poor rather than the medical care system. This approach would place public utility controls on the medical care system, with price, entry and quality controlled by regulation. However, experience in other regulated industries and other countries suggests the controls must be extremely powerful and carefully designed to work well, *most probably requiring that government have the power to fix the budget for regulated services in advance.* Regulatory intervention is the simplest approach to implement incrementally, but controls of the magnitude to work effectively will require substantial change in the medical care system, and will be a long difficult course politically.

C. Six Illustrative NHI Models and Their Prospects

Taking considerable liberty, existing NHI proposals fall roughly into the following models. Because they demand change, effective NHI models will be politically difficult to implement, whereas expensive ineffectual models are politically easy to fall into.

1. Two Models Likely to Fail

Model 1. The Present Medical Care System with Universal Third Party Coverage.

This model would leave the present medical care system unchanged and simply extend comprehensive third party reimbursement insurance to all. Because it leaves existing institutions alone, it would attract considerable initial political support. But, as noted in section A. above, this model will severely aggravate cost escalation. It is therefore unstable; runaway cost will force intervention, probably in the form of ever increasing regulation, and the nation will eventually move at great expense to a more successful model.

Model 2. Piecemeal Public Utility Controls with Universal Third Party Coverage.

This model establishes public utility controls on the separate pieces of the cost equation: price and fee controls, utilization controls, facilities controls, etc. The model will likely fail, even with quite strong controls. As Phase III showed, even if prices and fees are well controlled, total costs go up because providers can always increase the quantity and mix of services toward higher style. But (besides difficulties of sheer volume and the ill-defined nature of services) control of service quantity and mix requires medical judgment, an impossible conflict of interest. All regulated industries risk capture by the regulated; this approach virtually demands it. Nevertheless, because regulation can be incrementally implemented, this model will be politically popular. The danger is that as costs continue to escalate, the medical care system will be immobilized under ever increasing, expensive but ineffectual controls difficult to dismantle when the nation finally tries to move on to a more successful approach.

2. Four Models That Might Work

Model 3. Universal Major Risk Insurance (MRI).

This model emphasizes consumer cost sharing. The consumer is totally insured, but only for medical expense in excess of 10% of his income. (The plan could be even more strongly income related if desired). Thus while totally protected financially, consumers would pay most medical bills out-of-pocket, placing powerful market pressure on consumers to use care prudently and, thereby, on providers to hold cost. This approach would have to be supplemented with strong controls on catastrophic care. However, the great majority of people now have basic benefits below the income-related deductible of MRI, vitiating MRI's cost-sharing approach. These benefits would probably have to be legislated away under an MRI approach, politically impossible at present.

Model 4. Prepaid Alternative Delivery Systems with Universal Coverage.

This model emphasizes provider incentives, and is based on the fact that HMOs and other prepaid comprehensive care organizations reverse the present incentives on providers and reward cost-effective performance. This model would stimulate a pluralistic private system with consumers choosing among prepaid alternative delivery systems and traditional provider insurance plans on the basis of price, benefits and service. Consumers would have an income-related subsidy or voucher to assist purchase of an adequately comprehensive plan. However, while the medical care system remains private and government regulation minimal, there must be a large number of the new prepaid alternative systems sufficient to impact traditional provider behavior. Prepaid delivery systems can be stimulated incrementally, but encouraging the necessary private initiative and acceptance for the large number of new systems needed will be politically difficult.

Model 5. Public Utility Allocation Model (Akin to British Approach).

This model converts the entire medical care system into a public utility with a fixed budget. Consumers have comprehensive coverage. The budget could be allocated to providers directly or, alternatively, by incentive reimbursements retroactively adjusted to stay within the budget. Strong regulatory controls on manpower, facilities and services are also required to assure the budget is not exceeded. Unlike piecemeal public utility controls, which use medical judgment to determine costs, this approach specifies overall budget in advance and uses medical judgment to allocate within this fixed amount. However, while regulation can be implemented incrementally, public intervention of the magnitude required for this model is unprecedented.

Model 6. Public Utility Hospital Model.

This model converts just the hospital sector into a public utility (rather than the entire system as in the previous model), placing both hospital services and inpatient physician services under a fixed overall budget. Strong regulatory controls on hospital size, service mix, medical staff and manpower are required to assure that the budget is not exceeded. Consumers have comprehensive coverage, with ambulatory care costs contained by strong, income-related cost-sharing. Because the regulatory controls can be implemented incrementally and are less demanding (but also less certain to work) than in the previous model, this model may have the best eventual political chances. Nevertheless, this model requires exceedingly strong public intervention and control, which will be politically long and difficult to achieve.

3. Further models combining all three approaches—consumer cost-sharing, provider incentives, and public utility controls with a fixed budget—seem possible and may be more attractive technically and politically, but further study is needed.

Consumer market approaches may help take some of the cost containment and political pressure off public utility regulation, and vice versa. But additional study is needed to assure that such different approaches complement rather than defeat each other.

RECOMMENDATIONS

1. NHI plans should be built around a credible cost containment strategy.

Effective cost containment must be central to any NHI plan; it cannot be tacked on. Decisions on eligibility, benefits, financing and administration, as well as how fast to stage the plan, cannot be made before a cost containment strategy is arrived at. Otherwise, they will defeat rather than complement the cost containment strategy.

2. The necessity for change, and what the choices are, should be made widely known by public debate.

If the public and providers are to support needed change, more widespread understanding is needed that the provision of adequate health care and health insurance protection to all at a cost the nation can afford will require significant change in the American medical care system and its financing. The kind of medical care system we want under NHI—consumer market oriented, public utility oriented, or a combination of both—should be given informed, searching public debate.

3. Public debate should also focus on what immediate actions should be taken now, well in advance of NHI, on each of the three major cost-containment approaches so that we move toward the future system we want.

Such actions should be designed to learn what combination of approaches works and is acceptable, and should not foreclose the available choices. Possible actions include:

— Existing Cost-sharing
. . . might be made more uniform, simple and understandable, and consumers might be better informed of their choices, through "Truth in Health Insurance" legislation.

— Prepaid Alternative Delivery Systems
. . . might be more strongly encouraged through improved assistance legislation and Medicare and Medicaid reimbursement.

— Public Utility Regulation
. . . might focus on development of compulsory incentive reimbursement mechanisms presaging an eventual fixed budget approach, but in ways which do not discourage cost-sharing or prepaid alternative systems.

DOCTOR McCLURE, in his socioeconomic luncheon speech to Wisconsin physicians, also touched upon a report addressed to the question:

Should hospital capacity in the United States be reduced, and if so, how?

THIS PAPER highlights the major findings and recommendations of a report addressed to the question: Should hospital capacity in the United States be reduced, and if so, how? By capacity is meant not only hospital beds but the labor, service equipment, and plant assets associated with those beds; it is excess in the labor and capital intensity of beds, as well as in the number of beds, which generates excessive acute inpatient care cost. The report deals only with short-term general hospitals; the results below do not apply to long-term hospitals. While no single study of this difficult, value-laden issue can be definitive, the report is

The report on which this summary is based was prepared for the Bureau of Health Planning and Resources Development, Department of Health, Education, and Welfare, under Contract HRA-230-76-0086.

intended to suggest a solid and defensible basis upon which to initiate policy discussion and development.

Summary of Major Findings and Conclusions

The report finds substantial evidence of excess hospital capacity which contributes significantly to medical cost escalation with little or no benefit to health. If done in an orderly and appropriate manner, it would appear that hospital capacity in the United States could be reduced, conservatively, by at least 20% or more without harm to the health of the American people. The savings produced by capacity reduction could be substantial (up to several billion dollars annually), but depend crucially upon how it is done. More particularly:

— Hospital capacity could be reduced 5% to 10% simply by retiring idle capacity and using remaining capacity more efficiently.

Occupancy rates currently average 75% nationally. Retiring capacity until average occupancy rates were increased to 85%—an average rate that is both efficient and achievable in practice—would permit a 10% reduction in the national bed rate from its present value of 4.4 beds to 4.0 beds per 1000 population, assuming use rates remained unchanged.

— Increased hospital capacity of itself causes an increase in hospital use; conversely, reduction in hospital capacity appears to decrease hospital use.

Hospital use is correlated with hospital capacity rather than with indices of health or need. Excess hospital capacity thus aggravates excessive hospital use. Among quite comparable typical populations, hospital use presently varies from 600 to 1600 patient days per 1000 persons, a variation far greater than any known health risk factors in the population can account for. Research shows these variations in use to be closely tied to available hospital capacity, which ranges from less than 3 to more than 7 beds per 1000 persons, again far more than known population differences can explain. With respect to health, research suggests that a reasonably well organized health care system could adequately serve the U.S. population with as few as 600 to 800 patient days or less per 1000 persons (equivalent to 2.0 to 2.6 beds per 1000 persons at 85% occupancy); beyond this minimum level no correlation is observed between additional hospital use (or capacity) and such health indices as mortality, morbidity, disability and self-reported health status rates. In contrast, the present U.S. average is 1200 patient days (and 4.4 beds) per 1000 persons.

— Hospital capacity could be reduced at least an additional 10% or more without harm to health by retiring unnecessarily-utilized capacity.*

Given that current hospital use is so far beyond the minimum expected to affect health, it should be more than safe to bring areas of high use and capacity gradually down toward the present national average of 1200 patient days per 1000 persons, equivalent to a maximum of 4.0 beds per 1000 persons at 85% occupancy. (Such a maximum would of course need adjustment for area demographics and out-of-area use.) If appropriate capacity reduction in areas of above average use produced a modest 8% drop in the national average use rate (to 1100 patient days per 1000 persons), the current national average bed rate could be lowered by 20% (to 3.6 beds per 1000 persons at 85% occupancy). If use were further decreased to 1000 patient days per 1000 persons, which also appears quite safe, the bed rate could be dropped to 3.2 beds per 1000 persons, a 30% decrease.

— Similar excess capacity, both under-utilized and unnecessarily-utilized, appears to be present in high intensity service facilities.

While no national studies are available, studies in areas of high use find such highly labor and capital intensive facilities as coronary care units and cardiac surgery units to have capacity often as much as double the most optimistic projections of use or need. And for many patients in these facilities, much lower intensity treatment would be equally appropriate.

— The savings produced by reducing excess hospital capacity could be substantial, but depend crucially upon how it is done: retiring entire hospitals produces substantially more savings than an equivalent reduction closing portions of several hospitals.

A 10% reduction in hospital capacity, if accomplished by retiring entire hospitals, could reduce annual hospital expenditures by, roughly, up to 8% or so. (In 1975, an 8% reduction in annual hospital expenditures nationally would have amounted to $3 billion). These substantial savings result both from reduced hospital use, due to tighter supply, and from more efficient use of remaining hospitals. The resulting savings would repay the "sunk capital cost" of the retired hospitals within two to four years. In contrast, a 10% capacity reduction achieved by taking across-the-board general cuts at each hospital would produce savings of only 1% or so in annual hospital expenditures. Savings are low because such across-the-board general cuts neither constrain use well (beds are easily set-up and taken down) nor produce more efficient use of other hospitals. A 10% capacity reduction achieved by consolidating and eliminating duplicative, under-utilized service departments among hospitals would produce savings of 4% or so, intermediate between retiring entire hospitals and general reductions at each hospital. A moratorium on net increases in hospital capacity in areas of growing population would eventually produce savings equivalent to retiring whole hospitals. In any of these approaches, additional savings would result from reduction in inpatient physician expenditures, but these would be offset at least in part by increases in ambulatory care expenditures. A 20% reduction in hospital capacity would roughly double these estimated savings.

— Savings from hospital capacity reduction will be gradually eroded unless hospitals are restrained from excessively increasing the labor and capital intensity of the remaining beds.

The principal cause of excess hospital capacity (and excessive health-care cost escalation generally) is the combined incentive effects of the present health-care system coupled with present comprehensive insurance (both public and private). Thus insurance lowers the price to the consumer and provides a virtual blank check to the physician and hospital, encouraging a spare-no-expense approach as hospitals add and improve desired programs and compete for physician staff and institutional prestige. Any hospital which tries individually to restrict its own capacity can be

*The difference between high and low hospital use rates does not represent any conspiracy of providers to over-provide the American people with hospital services. Rather it represents differences in medical practice styles, some emphasizing liberal use of the hospital and others more conservative use. Both styles appear capable of producing equally good health results. Therefore, by the term "unnecessarily-utilized" we do not imply bad medical care; we simply mean that equal health results could be obtained by less costly alternative styles of practice. Whether more moderate styles of hospital use are too utilitarian for the tastes of American patients and providers remains an open question.

seriously hurt by this competition. The incentives of the health-care system are thus geared to over-emphasize intensive hospital use and capacity. Research on present bed controls (certificate-of-need laws) suggests that where these controls have successfully restrained bed increases, hospitals have simply maintained revenues from third party payers by increasing the labor and capital intensity of beds more rapidly, so that per capita operating and capital costs have risen unabated.

— While effective reduction of hospital capacity would likely restrain excess hospital use and expenditures, if equal attention is not given to restraining hospital demand, patient queuing and the necessity for increased public-utility types of controls may be significant side-effects.

If excessive demand for hospital care remains high while supply is reduced, increased public utility controls will be necessary to restrain remaining hospitals from increasing the amount and intensity of their capacity and/or from engaging in semi-monopolistic pricing, physician selection, and patient selection practices. Patient queues (i.e. waiting for non-urgent admissions) may also occur, particularly in areas where hospital-oriented specialists are excessively concentrated. While not a threat to health if admissions are properly prioritized, patient queuing could cause troublesome political reaction. Both side-effects would be much diminished by successful demand reduction. Since physicians create the demand for hospital care at least as much as do patients, successful measures to reduce hospital demand will have to be aimed at both physicians and consumers. The substantial projected increase in physicians, particularly hospital-oriented specialists, is expected to strongly heighten demand.

— Hospital capacity reduction is even more a socio-political problem than a technical problem.

Technical tools to identify and reduce excess hospital capacity are crude and need refinement, but they are more than adequate to begin; the chief barrier to reduction is the absence of any climate of public support. Even England and Canada, with staggering regulatory authority over their hospitals, have had to proceed quite slowly in reducing excess hospital capacity because of public and provider reaction. Tax subsidies and employment insurance hide the cost consequences of excess hospital capacity from communities that overbuild, but the impact of capacity reduction on local convenience, employment and prestige is immediately apparent. Americans are largely unaware of how excessive their current levels of hospital use and capacity are from a health standpoint, or how much they are paying for this excess. How far and how fast excess hospital use and capacity can be reduced may largely depend on whether the public and providers can be educated to accept some trade-off between the more lavish level of hospital care to which they have become accustomed, and their desires to free resources for other purposes more productive of health and well-being.

Summary of Major Recommendations

The report recommends that the United States adopt an initial policy goal to reduce hospital capacity by 10% over the next five years by raising average occupancy toward 85% and by bringing areas of high use and capacity down toward a target ceiling of 4.0 beds per 1000 population (with associated ceilings on hospital labor, service facilities and capital assets per 1000 population). A longer term policy goal of lowering this target ceiling eventually to 3.6 beds per 1000 should also be considered. The report recommends that this goal be carried out by a combination of actions to reduce both hospital supply and demand.

Actions to reduce hospital supply include: direct reduction of hospital capacity by a variety of means—including private sector pressure, financial and other inducements, licensure controls, reimbursement controls and capital controls—in areas having low occupancy and/or high capacity in excess of the target ceilings; and a moratorium on net increases in hospital capacity in areas of more moderate capacity (and in high capacity areas where population is growing rapidly). Where direct reduction of excess capacity is employed, first priority should be given to retiring entire hospitals, second priority to retiring service departments, and third priority to general bed cuts at each institution.

Actions to reduce hospital demand include: encouraging more front-end cost-sharing in existing hospital insurance; encouraging a variety of alternative delivery systems with intrinsic incentives to hospitalize less; placing reimbursement controls on inpatient physician services in areas of high hospital use; limiting the supply of hospital-oriented physician specialists; and shifting the emphasis of physician education to include ambulatory alternatives to inpatient care.

Hospital capacity reduction is a long-term proposition offering no quick or easy fix. Initial efforts in this strategy would emphasize setting goals and building public support, encouraging private sector efforts (by group buyers as well as providers), sponsoring demonstration projects, and strengthening the technical and administrative systems necessary. Later stages would become more systematic and, if necessary, coercive. ■

- **Public Health Service Recommended Treatment Schedules for Gonorrhea**
- **Rules for Estimating Disabilities in Workmen's Compensation Cases**

Each article is available upon request to the *Wisconsin Medical Journal*, Box 1109, Madison, Wis 53701; tel 608/257-6781.

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called for jury duty and wish to take advantage of your exemption, you should contact your attorney.

OB-GYN, PEDIATRICS SPECIALists needed by 16-man multispecialty clinic in university community of 50,000 in Western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R Ujda, MD, LaCrosse Clinic, 212 South 11th St, LaCrosse, Wis 54601.
9-12/76,1-8/77

FAMILY PRACTITIONER: ONE or two to join board surgeon and family practitioner in clinic with attached 82-bed JCAH hospital and nursing care unit all under one roof. Modern new facilities and equipment 45 miles from Minneapolis, rural living with all urban advantages. Financial arrangements open, Service Corporation. Contact John O Simenstad, MD, Osceola, WI 54020. Tel: 715/294-2116. 4-5/77

MEDICAL FACILITIES

OFFICE SPACE AVAILABLE: whole floor 3400 sq ft or part of floor for smaller office is desired. Will divide and remodel to your choice. Located in downtown Milwaukee, 174 West Wisconsin Ave. Convenient to all transportation and expressways. Parking garage in rear of building. Suitable for professional offices. Medical or dental laboratory facilities could be developed. Reasonable rent, long term lease if desired. Contact: Jay N Bhore, MD, 414/765-0225 or Patrick Meade, 414/276-1920.
7-12/76, 1-6/77.

OFFICE SPACE FOR RENT: Courtland Medical Center Building. Excellent location - 68th at West Capitol Drive, Milwaukee, Wis. Full lab and x-ray facilities available. Call 414/463-3704. 3/77*

USED EQUIPMENT WANTED TO buy by family physician starting new office. Furniture, office business, exam, and lab equipment needed. Reply in writing to S J Carlson, MD, 123 Bayview, Shell Lake, WI 54871. 5-6/77

FOR LEASE: OFFICE SPACE IN professional building two blocks east of West Allis Hospital. Entire ground level. 2400 sq ft. Parking lot. Will divide or remodel. Upper level occupied by two pediatricians. Available now. Contact Lincoln Properties, Inc, 8511 West Lincoln Ave, West Allis, Wis 53227; phone 414/543-8860. 5-7/77

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

AN EXCEPTIONAL RURAL PRACtice available in North Central Wisconsin with new fully equipped office for sale or rent 7 miles from open (small 47-bed) hospital where five other family physicians practice and share the emergency room call, which is one evening per week and one week-end per month. Model small city where new nursing home is located. Contact Dept 451 in care of the Journal. p6/77

OFFICE FACILITIES WITH COMplete laboratory and x-ray for general practitioner, internist or OB-GYN located in medical arts building, southwest suburb of city of Green Bay, Wis. Easy access to three hospitals. G E LeMieux, MD, PO Box W-200, De Pere, Wis 54115. 6-8/77

WANTED TO BUY: EXAMINAtion room table, horizontal file, cabinets, office furniture, etc. Contact: E G Arellano, MD, tel: 414/324-5043 or 414/324-5581. 5tfn/77

OFFICE SPACE AVAILABLE: 1100 sq ft, Lincoln Center Professional Building, West Allis. Tel: 414/321-2720.
5-6/77

WISCONSIN MEDICAL JOURNAL, September 1943 issue, needed for binding, or complete set or volume for year 1943. Willing to pay. *Wisconsin Medical Journal*, Box 1109, Madison, Wis 53701; tel: 608/257-6781, ext 125. 4tfn/77

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Healthy Pregnancy The Yoga Way. By Judi Thompson. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1977. Pp 148. Price: $3.95.

How to Feed Your Hyperactive Child. By Laura J Stevens, George E Stevens, & Rosemary B Stoner. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1977. Pp 240. Price: $7.95.

Lupus: The Body Against Itself. By Sheldon P Blau, MD and Dodi Schultz. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. Pp 120. Price: $5.95.

The Way We Die. By David Dempsey. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. 1977. Pp 276. Price: $3.95.

The New Health Professionals. Edited by Ann A Bliss and Eva D Cohen. Aspen Systems Corp, 20010 Century Blvd, Germantown, MD 20767. 1977. Pp 451. Price: $22.00.

Bibliography of Bioethics. Edited by LeRoy Walters. Gale Research Co, Book Tower, Detroit, MI 48226. 1977. Pp 282. Price: $24.00. ■

RECREATION PROPERTIES

GREAT LAKES FRONTAGE
4000 ft of Lake Michigan frontage, beautiful sandy beach with gradual drop off, 69 acres of land, 3 miles south of Thompson and its Coho fishing. 100 miles west of Mackinac Bridge.
($43.75/foot)
PRICE $175,000

LAKE FRONTAGE
Allen Lake. 625 ft of frontage, sandy beach, 5.8 acres, densely wooded, cleared cabin site. Gravel driveway, nice view, telephone, and electric lines on property. Permanent home site potential. Restrictive covenants. 1/4 mile east of US 45, 5 miles north of Land o'Lakes, WI. Gogebic County, Mich.
PRICE $25,000

HUNTING TRACTS
Douglas County parcels, (4) 40 acre and (1) 80 acre densely wooded parcels. Varied terrain and timber types. Excellent access road. 1/4 mile west of county road. 80 acre parcel has 5 acre 10 ft deep private lake, 20 miles south of Superior, WI.
PRICE. .40 acre parcels, $6,500 and $7,000; 80 acre parcel, $15,500

RIVER FRONTAGE
PRESQUE ISLE RIVER: 5 large wooded parcels. Frontage from 229—1,300 ft. 2.6—10.9 acres, 3 of parcels have frontage on black top county road, power line adjacent. Cleared and leveled cabin sites, gravel driveways, permanent home site potential. Restrictive covenants. Good location 1 mile north of Presque Isle, Northern Vilas County, WI.
PRICES .$4,200-$5,900

For detailed information and "Property Listing" write or call
Kimberlands Ltd
A subsidiary of Kimberly Clark Corp.
Phone 906/774-7235
PO Box 2167,
Kingsford, Mich 49801

University of Wisconsin-Madison Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

CME Calendar—1977

Aug 10-12: *The Second International Meeting on Tryptophan Metabolism: Biochemistry, Pathology and Regulation,* Dr Ray Brown, Chairman, The Wisconsin Center, Madison. Fee: $70.

Aug 29-Sep 2: *Emergency Care Conference,* The Wisconsin Center, Madison.

Sep 7: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Sep 10-11: *50th Anniversary Anesthesiology Program,* The Wisconsin Center, Madison. Fee: Members $27; Nonmembers $62.

Sep 15-18: *Family Physician Refresher Course,* The Edgewater Hotel, Madison. Fee: $125.

Sep 21: *Maternal and Infant Care: Infant Assessment and Early Management,* Beaver Dam Community Hospitals, Beaver Dam.

Sep 30-Oct 1: *Hospital Administration,* The University Bay Center, Madison.

Sep 30-Oct 1: *A Conference on Dermatology,* The Wisconsin Center, Madison.

Sep 30-Oct 1: *Trauma Symposium,* St Marys Hospital Medical Center, Madison.

Oct 19: *Maternal and Infant Care: Special Neonatal Problems I,* Beaver Dam Community Hospitals, Beaver Dam.

Oct 25-28: *Educational Resources,* University Bay Center, Madison.

Oct 26-28: *50th Anniversary Preceptorship Program,* The Wisconsin Center, Madison

Nov 3: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Nov 4-5: *Plastic Surgery for the Primary Care Physician,* The University Bay Center, Madison.

Nov 10-12: *Interventional Radiology,* The Wisconsin Center, Madison.

Nov 16: *Maternal and Infant Care: Special Neonatal Problems II,* Beaver Dam Community Hospitals, Beaver Dam.

Nov 17-19: *A Conference on Epilepsy,* The Wisconsin Center, Madison.

Dec 21: *Maternal and Infant Care: Optional Assessment of Series,* Beaver Dam Community Hospitals, Beaver Dam.

Info: Coordinator, Dept of CME, 601 Walnut Street, Madison, Wis 53706; phone: 608/263-2850.

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 9, 1976.

1977 WISCONSIN

Jul 15-16: Dr A Jampolski, sponsored by Dept of Ophthalmology, University Hospitals, Madison.

Jul 17-22: Eleventh Annual Summer Institute: *Strengthening Community Programming in the Field of Alcohol Abuse and Alcoholism,* University of Wisconsin Campus, Madison. Info: Richard F Buckley, Associate Professor, Center for Social Service, UW-Extension, 322 Lowell Hall, 610 Langdon St, Madison, Wis 53706.

Aug 5-6: *Third Annual Sports Medicine Symposium,* Waunakee Public High School, Waunakee. See details elsewhere in this issue.

Aug 23-24-25-26: *Aging in Wisconsin.* One-day seminars at four locations: Madison (23), Eau Claire (24), Green Bay (25), and Milwaukee (26). Presented by Wisconsin Health Care Review Inc (WHCRI). Special interest to physicians, medical directors, nursing home administrators, directors of nursing, and consultant pharmacists. See details elsewhere in this issue.

Sep 10-11: *Academic Anesthesia: Fifty Years After* Conference, University of Wisconsin, Madison. Objectives: The appointment of Ralph M Waters, MD to the faculty of the University of Wisconsin in 1927 marked the beginning of a new era in anesthesiology. All sessions at Wisconsin Center. Conference fee: $27 for members of Wisconsin Society of Anesthesiology, $62 nonmembers. Info: CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

Sep 16-17: Dr Robert Shaffer, sponsored by Dept of Ophthalmology, University Hospitals, Madison.

CONFERENCES FOR MEDICAL PROFESSIONALS.

Over 500 listings of national/international meetings, conferences and seminars in the medical sciences for 1977. Send a $10.00 check or money order payable to Professional Calendars, PO Box 40083, Washington, DC 20016. p1-6/77

Enjoy a Hawaiian Holiday—
Surf, Sun and CME

AMA Regional CME Meeting
Honolulu, Hawaii
October 30-November 4

Offers an ideal blend of study and sun. Morning hours are devoted to study. Up to 23 hours of Category 1 credit may be earned, with 53 credit hours of Category 1 available. After 1:00 pm you are free to pursue Hawaii's abundant pleasures.

In 1977, the AMA also is offering Regional CME Meetings in the following picturesque settings:

Tan-Tar-A Golf and Tennis Resort
Osage Beach, Missouri
September 16-18

Sawmill Creek
Huron, Ohio—October 7-9

The Homestead
Hot Springs, Va.—Sept 30-Oct 2

Send for your brochure on Hawaii or any of the other AMA Regional CME Meetings: Dept of Meeting Services, AMA, 535 N Dearborn St, Chicago, Ill 60610.

Sep 21: *Green Bay One-day Seminar for Family Physicians,* at St Vincent Hospital. Further details later.

Oct 7-8: *Geriatric Seminar: What's New for the Old.* Sponsored by Dept of Family Practice, Medical College of Wisconsin, and American Geriatrics Society. Mequon Care Center, Mequon (near Milwaukee). See details elsewhere in this issue.

Oct 7-9: Wisconsin Radiological Society, Concourse Hotel, Madison.

Oct 19: *Green Bay One-day Seminar for Family Physicians,* at Bellin Memorial Hospital. Further details later.

Nov 16: *Green Bay One-day Seminar for Family Physicians,* at St Vincent Hospital. Further details later.

1978 WISCONSIN

Jan 19-21: *Winter Refresher Course for Family Physicians.* Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians. Pfister Hotel and Tower, Milwaukee. See details elsewhere in this issue.

1977 NEIGHBORING

Sep 26-30: *Family Practice Review and Update—1977,* a continuing medical education course sponsored by the University of Minnesota, Minneapolis, at the St Paul Radisson Hotel. This annual, five-day course is designed to meet the needs of physicians preparing for certification or recertification in family practice, or those wishing a comprehensive general review. All major fields of medicine and surgery are presented in a systematic manner. Fee: $245. Approved for approximately 40 perscribed hours by the AAFP and AMA Category 1 credit.
Info: Office of Continuing Medical Education, Box 293, Mayo Memorial Bldg, 420 Delaware St SE, Minneapolis, Minn 55455; (612) 373-8012.
g6-8/77

Sep 29-30: *Recent Advances in the Care of the Aging Patient,* a clinical program on geriatrics sponsored by the Illinois State Medical Society's Com-

THIRD ANNUAL SPORTS MEDICINE SYMPOSIUM

Friday-Saturday/August 5-6
Waunakee Public High School
(near Madison)

Designed for coaches, trainers, physical therapists, physicians, and interested parents.

Faculty will include Doctor James Andrews, Team Orthopedist, Auburn University; Doctor Merrill Ritter, Team Orthopedist, Indiana University; Doctor William Clancy, Team Orthopedist, University of Wisconsin; et al.

A separate physicians' program will be presented. Fee: $50 for physicians, $20 all others. Fee includes tuition, materials, breaks, lunch on Saturday and dinner Friday evening.

Accredited by AMA for Category 1 and University of Wisconsin-Extension for Continuing Education Hours.

For further information, write or call Dennis M Day, 456 WARF, 610 N Walnut St, Madison, Wis 53706; (608) 263-2860.

Workshops for Health Professionals

A series of Continuing Medical Education conferences, offering 15 credit hours in Category II. Emphasizing how to use Biofeedback and transcutaneous electrical nerve stimulation in your practice. Write for brochure:
The Pain and Health Rehabilitation Center
Route 2—Welsh Coulee
LaCrosse, Wis 54601
Tel: 608/786-0611

Medical College of Wisconsin CME Courses in Milwaukee

* * *

GERIATRIC SEMINAR
What's New for the Old

Friday-Saturday/October 7-8
Mequon Care Center/Mequon
(near Milwaukee)

One and one-half days. AMA Credit, 10 hours; AAFP Credit, 10 Hours. Fee: $90.

Course director: Donald J Welter, MD, Professor and Chairman, Dept of Family Practice, MCW.

Sponsored by: Dept of Family Practice, Medical College of Wisconsin, and American Geriatrics Society.

* * *

Winter Refresher Course for Family Physicians

Thurs-Fri-Sat/Jan 19-20-21, 1978
Pfister Hotel & Tower/Milwaukee
Two and one-half days. AMA Physician's Recognition Award, 16-18 credit hours. AAFP, 16-18 credit hours.

Course director: Thomas F Garland, MD, Associate Professor of Family Practice, and Program Director, Family Practice Residency Program, Deaconess Hospital.
Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians.

* * *

Further details: Dept of Family Practice, MCW, 610 North 19th St, Milwaukee, Wis 53233.

AGING IN WISCONSIN
Seminars on Long-term Care

Wisconsin Health Care Review, Inc (WHCRI) will present statewide seminars focusing on the needs of residents in skilled nursing facilities:

Tuesday/Aug 30/Madison
Wednesday/Aug 24/Eau Claire
Thursday/Aug 25/Green Bay
Friday/Aug 26/Milwaukee

These one-day seminars will be of special interest to physicians, medical directors, nursing home administrators, directors of nursing, and consultant pharmacists.

Topics include:

- Alternative Care
- Psychological Needs of the Aged
- Drugs in the Long-term Care Facility
- Reorganization of HEW
- Independent Medical Review/Independent Professional Review Process

Registration materials and further information may be obtained by contacting: WHCRI, 330 East Lakeside St, Madison, Wis 53715.

Zip up to Michigan's beautiful Upper Peninsula for a weekend—

and come home with up to 12 hours of CME credits

AMA Regional CME Meeting

Cosponsored by the Michigan State Medical Society, Marquette, Michigan

Sat-Sun, August 13-14

Bring the family along.

While you're earning Category 1 credit, there's plenty for them to do and see—swimming, tennis, or nature walks through one of America's most spectacular wilderness areas. Courses offered are:

Saturday (6 hours: $70)

- Management of Coronary Artery Disease and Common Cardiac Arrhythmias
- Rational Use of Antibiotics

Sunday (6 hours: $70)

- Management of Diabetes
- Practical Management of Hypertension
- The High Risk Obstetrical Patient

Further info: AMA Dept of Meeting Services, 535 North Dearborn St, Chicago, Ill 60610.

1977 NEIGHBORING

mittee on Aging, in cooperation with the AMA, to be held in Oakbrook, Ill. Sessions are aimed primarily at the general internist, family physician, neurologist, surgeon or psychiatrist with a special interest in geriatrics. Tuition for the two-day program is $150. Info: Illinois SMS, 55 East Monroe St, Chicago, Ill 60603; (312) 782-1654. g6-8/77

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

July 11-August 7
Drugs and the Menopause Workshop

This telecourse is cosponsored for continuing medical education credit by the AMA Council on Continuing Physician Education, and qualifies for one-hour of Category 1 credit for the Physician's Recognition Award of the AMA. It also is accepted for one-hour of Prescribed credit by the American Academy of Family Physicians. AOA members may earn credit in Category 2.

Program features John Moyer, MD, Director of Professional and Educational Affairs, Conemaugh Valley Memorial Hospital, Johnstown, Pa; Elizabeth Connell, MD, Associate Director of Health Sciences, Rockefeller Foundation, New York City, and consultant to Obstetrics and Gynecology Advisory Committee of FDA; Herbert Kupperman, MD, PhD, Director of Endocrinology, Lenox Hill Hospital and Associate Professor of Medicine, New York University Medical Center, New York City; Theodore King, MD, PhD, Chairman of the Department of Obstetrics and Gynecology, Johns Hopkins Medical School, Baltimore, Md, and Chairman of the FDA Obstetrics and Gynecology Advisory Committee.

This presentation is part of the American Society for Clinical Pharmacology and Therapeutics' Drug Spotlight program.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in most videotape and videacassette formats.

Oct 26-28: *Rights of children as research subjects* will be argued in a conference at the University of Illinois at Urbana-Champaign. Sessions to be held at Ramada Inn, Champaign. Info: Ronald G Sears, Conference Director, 116 Illini Hall, University of Illinois, Champaign, Ill 61820. g6-9/77

1977 OTHERS

Aug 15-18: Fifth Western Hemisphere Nutrition Congress: *Nutrition in Transition,* in Quebec City, Canada, held under auspices of the American Medical Association, American Institute of Nutrition, Nutrition Society of Canada, Sociedad Latinoamericana de Nutricion, and American Society for Clinical Nutrition. Info: Dept of Foods and Nutrition, AMA, 535 North Dearborn St, Chicago, Ill 60610. g4-7/77

Oct 31-Nov 1-3: *62nd Annual International Scientific Assembly of Interstate Postgraduate Medical Association,* at Diplomat Hotel in Hollywood, Fla. Further info: Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701. g6-9/77

Nov 4-5: *Conference on Cancer of the Bladder and Prostate,* American Cancer Society-Kentucky Division, at Stouffer's Inn, Louisville, Ky. Info: George A Sehlinger, MD, President, ACS-Kentucky Div, 2313 Medical Arts Bldg, Louisville, Ky 40217. g5-10/77

1977 AMA

Aug 8-13: "Medinfo '77"—2nd International Conference on Medical Computing, cosponsored by the Canadian Medical Association, International Federation for Information Processing; and World Health Association.

Aug 13-14: AMA Regional CME Meeting, cosponsored by Michigan State Medical Society, at Marquette, Mich.

Sep 16-18: AMA Regional CME Meeting, Tan-Tar-A Golf and Tennis Resort, Osage Beach, Mo.

Sep 30-Oct 2: AMA Regional CME Meeting, The Homestead, Hot Springs, Va.

Oct 7-9: AMA Regional CME Meeting, Sawmill Creek, Huron, Ohio.

Oct 30-Nov 4: AMA Regional CME Meeting, Honolulu, Hawaii.

Nov 10-11: AMA 16th National Conference on Physicians and Schools, Regency Chicago, Chicago.

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Dec 20-23: AMA National Leadership Conference.

Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

CONTRIBUTIONS—CES FOUNDATION
April 1977

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for April 1977.

Unrestricted

Anonymous; Manuel Aquino, MD; Thomas G Malloy, MD; David D Melleneamp, MD; Eau Claire-Dunn-Pepin County Medical Auxiliary—*Voluntary Contributions*

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MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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The foregoing principles may be changed at any time without notice.

"Bureau" as used above refers to the State Medical Journal Advertising Bureau, Inc., Oak Park, Illinois.

NEWS YOU CAN USE

RNs MAY SELL BIRTH CONTROL PILLS

Attorney General Bronson LaFollette has ruled that registered nurses may sell contraceptive articles, including birth control pills. LaFollette said he believes the purpose of the Wisconsin contraceptive law is to help famliy practice clinics by allowing registered nurses to sell contraceptive articles without a physician being present. Previously only licensed physicians or registered pharmacists could lawfully offer to sell or sell contraceptive articles. See further details on page 32 of this issue.

REPRINTS OF THE "HEALTH COST" BROCHURE

Since its introduction in April, physician members of SMS have ordered about 100,000 reprints of a brochure explaining health care costs. Prepared by the SMS Communications Department, the "health cost" brochure is available in any quantity upon request to the Dept, in care of SMS, Box 1109, Madison, Wis 53701.

SHEBOYGAN AREA PHYSICIANS AND LABOR FIGHT DRUG ABUSE

Sheboygan County physicians and labor leaders have united to fight drug abuse, particularly alcohol, in that area. Six physicians and five labor leaders have formed the Physician-Labor Committee on Drug Abuse. The panel is co-chaired by Henry Winsauer, MD, Sheboygan, and John Hayon, United Auto Workers labor leader. The Committee will hold its second meeting in June, and will first try to analyze the extent of drug abuse in Sheboygan County, followed by the development of potential solutions to the problem. The effort is being coordinated by the SMS Physicians Alliance staff.

PATIENT COMPENSATION PANELS ARE WORKING

The Patient Compensation Panel system under the Wisconsin Health Care Liability Insurance Plan is working. Jeffrey Kravat, director of the Panels, reports the panels have dealt with about 40 cases over the past year. About half of these have been completely closed, with the others still under consideration. So far, the Panels have awarded about $10,000 to patients (total), with several awards under $1000. Kravat adds that about half the cases have been decided in favor of the patient, the other half in favor of the physician.

SICK PAY

The Tax Reduction and Simplification Act of 1977 has reinstated the sick pay exclusion for employer paid disability benefits for 1976. Previously the Tax Reform Act of 1976 had revoked this exclusion retroactive to Jan 1, 1976. Those individuals who have filed their 1976 income tax return and paid tax on employer paid sick pay should file Form 1040X (Amended US Individual Income Tax Return) and attach to it a Form 2440 (Revised 1977) showing the computation. If for some reason an individual has not yet filed his 1976 return because of an extension, the sick pay exclusion can be claimed on line 15b of the 1976 Form 1040. A Form 2440 should be attached showing how the exclusion was determined. It should be borne in mind that the exclusion referred to in this article is applicable up to $100 a week. Amounts received in excess of $100 are taxable.

AMPHETAMINE ABUSE IN WISCONSIN

The State Medical Society once again is emphasizing its position that physicians limit the prescription and dispensing of amphetamines to recognized conditions where these drugs are indicated. See further details on page 45 of this issue. ■

EDS TAKES OVER MEDICAID ADMINISTRATION

Effective July 1, 1977 EDS Federal Corporation assumed responsibility for administration of the Medicaid (Title 19) program in Wisconsin. The new fiscal intermediary will headquarter in Madison for its Wisconsin activities, and will eventually hire a total of 400 people. Until physicians are informed otherwise, there will be no changes in claim forms or claims preparation procedures. *Claims for services rendered on or after July 1, 1977 should be prepared on current forms and according to current instructions, and submitted to EDS at this address:*

EDS Federal Corporation
6406 Bridge Road
Madison, Wisconsin 53784

EDS also urges physicians to continue use of the provider number which they currently use to bill the Medicaid program. For more complete information see the June 6-A issue of the GREEN SHEET.

A JOINT REVIEW OF HOSPITALS

The State Medical Society and the Wisconsin Hospital Association have persuaded the State Division of Health and the Joint Commission on Accreditation of Hospitals (JCAH) to review hospitals jointly rather than administering separate reviews. This should save physicians and hospital administrators considerable time and expense.

NOTIFY WPS OF CHANGES IN SPECIALTY OR CERTIFICATION

Physicians are reminded to notify WPSIC (Wisconsin Physicians Service Insurance Company) promptly of any change in their specialty or certification. This information is required and used by WPSIC in the administration of government contracts. It has been reported that *some* Wisconsin physicians list as many as three specialties, one with AMA, another with SMS, and still another with the State Medical Examining Board. Needless to say this can and often does present a problem. Again, physicians are asked to keep WPSIC informed of their current specialty by sending updated materials to: PO Box 1787, Madison, Wisconsin 53701—attention CPCU.

COST-OF-HEALTH ISSUE REVIVES USE OF AMA PLAQUE "TO ALL MY PATIENTS"

One practical way to approach the fee question is to revive use of the AMA plaque entitled, "To All My Patients." The attractive desk or wall piece reads: "I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between doctor and patient." Individual plaques are available from the AMA Order Dept for $2.40 each. For quantities of 100 or more the price is $2.19 each. Order No OP-33.

MULTIPHASIC SCREENING IN WISCONSIN

The Wisconsin Department of Health and Social Services, Section on Multiphasic Screening, reports that 38,850 persons received blood sugar tests in state-supported diabetes detection programs during 1976. Follow-up reports on 1,942 suspects referred to their physicians have not yet been completed. Screenees also had their blood pressure levels measured and were given the opportunity to be tested for glaucoma, hypertension, cholesterol, and uric acid levels, liver and kidney problems. Of 12,295 screened for glaucoma, 860 were referred for physician evaluation. The state's multiphasic screening program was phased out in March due to budget cutbacks. ■

the wisconsin medical journal

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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On intestinal fortitude

FOR YEARS OUR profession and the public have assumed that through our various medical societies we "police ourselves." But even in the old days when medical societies possessed clout—when denial or withdrawal of society membership caused loss of hospital privileges—the accuracy of that assumption was open to question. Now that expulsion from a county or state medical society no longer has as strong an effect on the privilege to practice, organized medicine must resort to other means to control unethical, incompetent, or just plain crooked physicians.

Within the State Medical Society of Wisconsin allegedly unethical or incompetent physicians are reviewed by two commissions, the Commission on Peer Review and the Commission on Mediation and Professional Ethics. Both possess means of investigating a physician's practice and making recommendations for action to the Council. But they are unlikely to uncover any problem before the news media do if they are not fed pertinent information early by concerned colleagues. There-in lies a great flaw in the system. Doctors have been unwilling to initiate action (except in rare instances) even when a colleague commits obvious errors repeatedly or when he is blatantly alcoholic or drug dependent.

The news media, legislators, and many physicians rightfully ask: "Why? Where was medicine's self-policing mechanism?" And what happens if a concerned colleague does report aberrations to the peer review or mediation committee? Lightning response is far from assured. Investigation can drag on for years without action. One such instance—wherein an investigation of two physicians has dragged on for at least two years—was reported to the Council at its last meeting. During that two-year period, the two physicians have gone merrily along without altering their practices at all. While a certain reluctance to move without careful study is understandable, two years delay in blowing the whistle on flagrant irregularities is inexcusable.

Physicians can no longer afford to sit back and unconcernedly watch a colleague drink himself into trouble or cover up for him if he's incompetent. Even if our consciences would permit it, the legislators won't anymore. The structure of the medical society is such that there are mechanisms to help the impaired physician, to educate if education is needed, and to punish if punishment is warranted. Let's put them into action. Our patients' well-being depends on it. Their well-being depends on our education, our training, and our judgment. It also depends on our having the guts to do what needs to be done.—WJB

A word to the dropouts

ENCOURAGING figures presented at the finance committee of the Council when it met on June 4 seemed to suggest that the drop in membership of the state and county societies has finally bottomed out, and in some areas has started to climb back up.

The big city areas have the largest numbers of physicians who are nonmembers, ranging from 12 to 18 percent of total numbers of physicians on county rosters. Why metropolitan doctors feel less need to belong is hard to understand. On the other hand some rural counties can boast close to 100 percent membership. We city slickers might take a lesson from these smart individualists who have the courage to practice all alone without even a CT scanner and yet recognize the need for a strong, unified voice in organized medicine.

Those of you who have considered dropping out must keep in mind that if the size of the Society dwindles so that it no longer represents the great majority of Wisconsin physicians, it will lose credibility as the voice of Wisconsin medicine, and will die. The day after the funeral a group will get together and organize a Wisconsin Medical Society to speak for Wisconsin medicine, and you'll join because you have to have a voice. It might even be a little cheaper at first, but as the new society grows so will its budget and in a year or so you'll be right back where you started. So why not dig in, pay your dues, elect responsible officers, do your fair share, and enjoy it.—WJB

We're going to get better!

RECENTLY a friend of mine was trying to tell me something. He's a man well worth your listening time.

Editorial Director—WAYNE J BOULANGER, MD, Milwaukee

Editorial Associates—PHILIP J DOUGHERTY, MD, Menomonee Falls; LESLIE G KINDSCHI, MD, Monroe; RAYMOND A McCORMICK, MD, Green Bay; T H McDONELL, MD, Waukesha; JOHN P MULLOOLY, MD, Milwaukee

Chairman of the Board of one of the nation's larger companies, he's been a member of two private hospital boards, a regional medical board, and an industry representative at several conferences of national import. He is well acquainted with many of the stresses with which medicine is currently struggling. As the father of a young physician, he has no personal axe to grind.

He hinted, as gently as he could, that in his view physicians have never had to face up to the disciplines with which most corporate executives in the business world must contend. Indeed, he suggested that the unique freedoms which we have enjoyed have allowed us to become at once: selfishly independent, undeservedly authoritarian, aggravatingly unbusinesslike, generally unmanageable, and securely convinced that we are the very center of the universe.

I've thought about his impressions of us for a time, and I believe they deserve an answer. So I shall write him a letter.

Dear Chairman of the Board:

I have respectfully considered your evaluation of physicians as an undisciplined and unmanageable lot, and I've decided that you are quite right in your assessment.

Upon further reflection, I have become convinced that you really wouldn't have it any other way. For I have known your personal physician for twenty-one years, and I am well aware of the great regard you have for him. Let me assure you that your doctor is most certainly authoritarian, in many respects undisciplined, and definitely unbusinesslike. But he also is honest, ethical, intelligent, human, exhausted, cantankerous, warm, and above all deeply concerned about your health.

We physicians have our faults, admittedly, but we beg you to avoid precipitous actions, because we are convinced that a free medicine is self-correcting. Trust us. We're going to get better and better if you'll give us a little more time. Maybe we can work it out together without the bureaucrats.

With kindest regards,
THM

Kudos

A RECENT Wisconsin graduate of the Palmer College of Chiropractic (modestly hailed as the first and world's largest chiropractic college) listed his numerous honors in his hometown newspaper.

Among these were membership in the Gonstead Club (the AOA of chiropractic?) and President of the Olecranon Flexion Foundation! Is this latter some orthopedic technique of which we are not cognizant, or is it an honorary convivial elbow bending group?

And with that background another chiropractor returns to Wisconsin.—VSF ■

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Usual and Customary Fee

To the Editor: In the May issue of the *Wisconsin Medical Journal,* Dr Jack A Killins resoundingly takes exception to actions taken by Surgical Care-Blue Shield in late 1976, which were intended to put some relativity back into the level of fees for open-heart surgery.

After months of deliberations, Surgical Care did suggest that current fee levels for open-heart surgery should be continued at the same level for the remainder of 1976 and all of 1977. It is unfortunate that Doctor Killins has interpreted such action not to be ultimately in the best interests of physicians and he appears to have missed the main point at hand.

Recent advancements in technology have substantially impacted on the associated cost of many medical, surgical, and diagnostic procedures. While some procedures have become increasingly complex and costly to perform, others have had the opposite effect. Where significant advancements in technology have occurred which should tend to reduce costs, our groups have demanded that such cost savings should rightfully be passed on to subscribers.

The "state-of-the-art" of performing open-heart surgery has vastly improved during the past decade. Where the heart surgical team once consisted of a combination of some four or five surgeons, surgical assistants and technicians, the average team today consists of one surgeon, one surgical assistant, and one or two technicians.

Similarly, as training and expertise in the procedure has progressed over the past 10 years, the amount of time required to perform the procedure has decreased from an average of eight hours to approximately four hours. Thus, the relativity of the procedure in terms of difficulty, risk, and time involved when compared to other surgical procedures has changed significantly in recent years.

Without question, it would have been much better if physicians, acting either as individuals or as a consortium, had voluntarily agreed to limit their own charges for open-heart surgery, but such was not the case. Realistically, one must question whether there is in fact any other effective vehicle other than an insurance Plan which can effectively accomplish such an objective.

Doctor Killins suggests in his *Letter to the Editor* that the decision to continue the existing fee level for cardiovascular surgery was made by the Board of Directors of Surgical Care while functioning in some kind of vacuum. Before making its decision on this matter, Surgical Care consulted with a number of heart surgeons from throughout Wisconsin who worked many months to arrive at a consensus as to what was felt to be a reasonable policy regarding fee levels for open-heart surgery. In addition, the fee levels experienced in Wisconsin were compared to prevailing fee levels which existed in other states.

In reviewing the situation, the Board was also concerned that apparently over the years, the relativity of fees for open-heart surgery had gotten out of line when compared to other surgical procedures. Since 1966, the prevailing team fee for open-heart surgery has increased from approximately $1800 to some $2844.

Doctor Killins also suggests that Surgical Care is not paying the Usual and Customary fee in many communities and that it might consider marketing a policy offering a fixed dollar indemnity. He seems to overlook the fact that it was physicians who were largely responsible for acceptance of the Usual, Customary and Reasonable reimbursement concept. The program provides physicians with the assurance that as technology advances within the medical profession and as costs are likely to increase, patients are not tied to insurance benefits offering fixed dollar indemnity payments which have frequently failed to keep pace with the reality of higher fees and an ever-improving medical technology.

In the eyes of Surgical Care, the decision by the Board of Directors last August to continue reimbursement levels for open-heart surgery at current Usual and Customary fee levels was felt to be a responsible course of action and that additional fee increases in 1976-1977 for open-heart surgery were neither justifiable nor reasonable.

JOSEPH DARIN, MD
Chairman of the Board
Surgical Care-Blue Shield ■

June 8, 1977

Insect sting incidence wanted

To the Editor: I am convinced that lives now needlessly lost due to severe systemic reactions to insect stings could be saved. How? By a greater awareness of the possibility of such fatal reactions plus knowledge of the existence of an insect sting kit. The kit is an emergency first aid measure to stave off anaphylaxis. Because of my convictions I am presently collecting and correlating data on incidence of such fatalities.

I am especially interested in time lapse between sting and death although information concerning the following would be helpful: (1) time sequence of symptoms, (2) previous reactions to insect stings, (3) medication on hand at time of sting, (4) type of medication, (5) type of insect, (6) number of stings, and (7) estimation as to whether or not a physician or hospital emergency room could have been reached in time to avoid a fatal outcome.

CLAUDE A FRAZIER, MD
4-C Doctors Park
Asheville, NC 28801 ■

April 19, 1977

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin.

WPS separate incorporation complete

As the culmination of efforts begun nearly five years ago, the State Medical Society of Wisconsin, as of June 30, 1977 transferred to Wisconsin Physicians Service Insurance Corporation (WPSIC) the business, assets, and liabilities of WPS.

WPS was established by the House of Delegates in 1946, and operated for 30 years as a division or part of the Society. It grew through the years to a statewide health-care plan which was carried by a substantial percentage of the population of Wisconsin. The plan's premium and investment income in 1976 reached $150 million. The assets transferred exceeded $70 million.

In 1976 the Legislature passed a law which required SMS to establish a nonstock, nonprofit service insurance corporation within a year, such corporation to be the successor to the Society-operated division known as WPS. SMS, acting through the Council, incorporated WPSIC and the Commissioner of Insurance, after conferences, negotiations, and a public hearing, issued a Certificate of Incorporation on April 27, 1977.

The following two months were spent in arranging the details of the many necessary transfers and other matters required by the change over. While some technical matters remain uncompleted, including a special audit directed by the Council, the transfers are substantially finished and the board, officers, and staff of WPSIC are now conducting the health insurance plan. It will continue to use the trade name WPS.

Under terms of the charter of WPSIC, the Council of the Society serves as the corporate membership of WPSIC with the power to elect its board of directors. This power is somewhat like that of shareholders in a stock corporation.

At present, the WPSIC board consists of the 17 physicians and five nonphysicians who comprised the WPS Commission, plus Mr Ray Koenig, president. After vacant positions have been filled, the board will consist of 17 physicians and 15 nonphysicians. The Commissioner of Insurance has directed that none of these members of the board may be replaced until July 1978. However, nine nonphysician members of the WPSIC board must be appointed by the Council before the end of this year.

The initial board of directors consists of the following persons whose name, city, and term of office are listed below (in alphabetical order):

Marvin E Brickson, Madison (1979)
William T Casper MD, Milwaukee (1978)
Eli M Dessloch MD, Prairie du Chien (1978), *Chairman*
Milton Finn MD, Superior (1979)
John S Garman MD, Waterloo (1978)
David N Goldstein MD, Kenosha (1980), *Secretary*
Thomas A Hofbauer MD, Menomonee Falls (1980)
J C Howdle, Madison (1979)
Raymond E Koenig, Monona (ex officio), *President*
Robert Krohn MD, Black River Falls (1978), *Vice-chairman*
John A May MD, Baldwin (1980)
John J McGloin MD, Neenah (1980)
Owen E Miller MD, Waukesha (1979)
Emil Muelver, Milwaukee (1978)
Cornelius A Natoli, LaCrosse (1979)
Eugene J Nordby MD, Madison (1980)
Dayton F Pauls, Sheboygan (1980)
Daniel K Schmidt MD, Milwaukee (1979)
Max M Smith MD, Madison (1978), *Treasurer*
John T Sprague MD, Madison (1978)
David L Vogel, Stoughton (1980)
Blake E Waterhouse MD, Madison (1979)
William E Wright MD, Mondovi (1979)

Mahlon Bontrager is vice-president but is not a board member. ■

Environmental health committee authorized

The Council, at its June 4 meeting, gave the Governmental Affairs Commission authorization to establish a Committee on Environmental Health. This committee will examine legislation concerning major environmental measures for their impact upon the health of Wisconsin citizens. ■

SMS opposes proposed licensing "super-board"

The State Medical Society has voiced its opposition to AB 784 which would create a three-person Occupational Standards Board (OSB), chaired by the Secretary of the State Department of Regulation and Licensing. The OSB would be the "super-board" for the licensing and regulation of *all* occupations and professions in Wisconsin.

The existing examining boards, including the Medical Examining Board, would exist *only* as advisory bodies to the OSB for the purposes of examinations, rule development, and disciplinary action. The membership of the OSB would include the Secretary, plus two public members appointed by the Governor.

AB 784 is a serious threat to medicine, since the OSB would handle license denials, revocations, suspensions, and appeals, rather than the Medical Examining Board. Nonprofessionals, political appointees of the Governor, would execute these license-related activities. The OSB would be a part-time citizen body, and it is questionable whether it could handle the workload.

For an explanation of this bill and other medical-related bills, contact the Physicians Alliance Division of the SMS at 608/257-6781, ext 115. ■

Dr Wayne Boulanger named new editorial director

The Council, at its June 4 meeting, appointed Dr Wayne Boulanger of Milwaukee as the new editorial director for the *Wisconsin Medical Journal*, succeeding Dr Raymond Headlee, Elm Grove, who resigned after serving six years.

Doctor Boulanger, also a councilor, served as an editorial associate. In late 1976 he was appointed to the Editorial Board, succeeding Dr David Ovitt of Milwaukee. ■

Committee name changes

At the June 4 meeting of the SMS Council, name changes were approved for the Commission on Public and Professional Affairs to the Commission on Mediation and Professional Ethics and the Committee on Nervous and Mental Diseases to the Committee on Mental Health to more accurately reflect the functions of each committee. ■

Council meeting August 6

The next Council meeting will be held at SMS headquarters in Madison, August 6. ■

Nominating Committee to meet

The SMS House of Delegates Nominating Committee will meet September 25 at 10:00 AM at SMS offices in Madison. ■

SMS Variable Annuity Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.28 as of May 31, 1977. ■

SMS members sent draft of provider contract

On July 1 all SMS members were sent a draft copy of the Wisconsin Medical Assistance Provider Contract which is being negotiated by SMS with the State Department of Health and Social Services (DHSS).

Some six months ago the DHSS informed the State Medical Society of the Department's decision to require a contract of all providers of services under the Medicaid Program. This is based on a 1976 law [Sec 49.45(2)(a)9, Wis Stats]. The DHSS will now require such contract as a condition of participation in the Medicaid Program.

The SMS has been negotiating with the DHSS to obtain the most reasonable provisions possible under the circumstances. The SMS has insisted upon, and has obtained, three very basic protections in the contract:

(1) That any decision affecting a physician's continuation in the program be protected by fair play provisions (*eg*, the provider is assured of due process under Chapter 227 if DHSS attempts to suspend payment or participation).

(2) The reimbursement schedule is to be incorporated in and made a part of the contract.

(3) Any physician provider may discontinue his participation in the program by giving 30 days' written notice to the DHSS.

These negotiations have been conducted on behalf of SMS and its members by the Physicians Alliance Commission, the MD members of the Statutory Title 19 Advisory Committee and staff, with continuing review and approval by the Council.

The resulting provider contract, now nearing completion, sets forth the terms and conditions under which the physician and other providers will be reimbursed for services under Title 19.

The principal features of the agreement are:

The DHSS is required to:

(1) Reimburse physicians according to the schedule set forth in the agreement.

(2) Pay all properly completed claims within 60 days.

(3) Assure the physician or other provider of due process under Chapter 227, Wis Stats, if DHSS wishes to suspend payment or participation.

The physician is required to:

(1) Comply with all federal and state laws, regulations, and administrative rules concerning Medicaid, but without waiving the right to challenge their validity.

(2) Submit claims on forms prescribed by DHSS.

(3) Accept as full payment the amounts paid by DHSS according to the "Terms of Provider Reimbursement" as provided by the contract. (Starting July 1, 1977 DHSS will pay for physicians' services under Title 19 at the same rate as they are paid for Medicare services.) DHSS must give notice of any proposal to change the reimbursement. The physician may terminate the contract at any time with 30 days' notice.

(4) Keep such records as are necessary to disclose the nature and extent of services or supplies provided to a T-19 recipient, and to grant DHSS appropriate access to those records.

Many of the proposed agreement's conditions affecting the physician have been in effect since 1966 under agreements signed by physicians each time they complete a claim form. However, important protections for the physician have been added including assurance of payment within 60 days, a clearly specified reimbursement level, a requirement that DHSS can terminate or suspend a physician's participation only according to statutory due process rules, and assurance of participation in the process for setting the reimbursement level. It is further highly significant that DHSS has agreed with SMS that all physician contracts be up for renewal annually and on the same date.

The final form of the contract, with annotated explanation, will soon be sent to every SMS member. Further information also will be provided as to the certification provisions of the DHSS (see separate story).

If further questions need answering, please feel free to call the SMS office in Madison: (608) 257-6781. ■

DISTINGUISHED SERVICE AWARD

DR THOMAS A LEONARD (left), Madison, received the Distinguished Service Award of the State Medical Society at the June 4 Council meeting in Madison. Making the presentation was Dr Richard Brown (right) of Eau Claire, chairman of the Maternal Mortality Study Committee. Doctor Leonard has dedicated his life and professional career to improving maternal and child care in Wisconsin. In 1951, he led the drive for establishment of the State Medical Society's Maternal Mortality Study Committee. Because of his efforts as chairman of this committee for 25 years prior to his retirement last year, the incidence of maternal mortality dropped significantly in recent decades. The Award reads, in part: "His genuine warmth and kindness as a physician, researcher, and human being have gained him many friends and admirers among his patients and colleagues. He serves as a continuing inspiration for those physicians entering the field of obstetrics." The Distinguished Service Award is granted on occasion by the SMS Council, upon recommendation of the Commission on Continuing Medical Education, in recognition of outstanding contributions to the science and art of medicine by individuals engaged in teaching and research in the basic sciences. (SMS Staff photo by Ken Opin)

FIFTY-YEAR CLUB AWARD: 1977 Members

ANNUALLY THE State Medical Society pays its respect to members who have served their profession and patients for 50 years. It is an honor which is expressed by fellow practitioners on behalf of the communities and patients who have been served by physicians of experience and integrity. At this year's Annual Meeting, April 14-16, there were 27 physicians so honored. Those who were able to attend the ceremony are pictured above (left to right): MDs Arthur C Taylor, Appleton; Nicholas D Demeter, Milwaukee; Chester W Long, Milwaukee; Carroll W Osgood, Milwaukee; Robert Krohn, Black River Falls; Hyman Mendeloff, Milwaukee; John S Wier, Fond du Lac; Alois F Kusterman, Milwaukee; Alford H Hermann, Milwaukee; Earl T Harrington, Milwaukee; Arthur H Thorstensen, Milwaukee; and Harry B Sadoff, Milwaukee. Unable to be present were: MDs William H Bennett, Racine; Myra E Burke, Madison; Alvin J Dupont, Green Bay; Josef A Kindwall, Milwaukee; J H Lundstrom, Elkhorn; George L McCormick, Waukesha; Clement A Meilicke, Wautoma; Sherburne F Morgan, Crowley, Texas; Thornton M Northey, Milwaukee; Raimunds Pavasars, Appleton; Burton S Rathert, Crandon; George E Skemp, LaCrosse; Willard C Sumner, Edgerton; Benjamin E Urdan, Milwaukee; and John F Wyman, Cedar Mountain, North Carolina. (SMS Staff photo by Ken Opin)

Provider certification rules finalized

The State Department of Health and Social Services (DHSS) has finalized rules which mandate that providers who wish to participate in the Medicaid Program be certified. Because the number of providers involved is large, the certification process will be phased in over the next few months. Meanwhile, physicians may continue to serve T-19 patients and receive reimbursement as in the past, but at the updated July 1 rate.

When a physician receives an application for certification, he will be asked to:

(1) Affirm in writing that he is licensed to practice medicine.

(2) Disclose any "controlling interest" which he may have in a hospital, nursing home, clinic, pharmacy, laboratory, or home health service.

(3) Affirm in writing that he has not been convicted of a crime in the past five years relating to federal or state-assisted medical programs and that he has not been terminated from such programs.

(4) Execute a provider contract (see separate story) with the DHSS.

A provider may lose his certification for:

(1) Revocation or suspension of license.

(2) Endangering the health or safety of a recipient by failing to abide by applicable state/federal statutes and rules and regulations.

(3) Conviction of a crime relating to the Medicaid Program.

(4) Failing to abide by the Federal Civil Rights Act of 1964 (discriminating against recipients in the provision of services).

(5) Referring a recipient to a vendor of drugs or medical supplies, or other provider, without disclosing at least once to recipient any controlling interest provider has in such vendor or other provider.

(6) Making a claim or receiving a payment for services not rendered.

(7) Falsely reporting a figure relating to costs, expenditures, or usual and customary charges.

(8) Giving or receiving a "kickback" for referral of a recipient.

(9) Failing to pay just debts to the Medicaid Program.

(10) Failing to maintain records required by the DHSS for this program.

(11) Knowingly violating any terms of the provider contract.

(12) Interfering with investigations or audits conducted by DHSS. ■

Leadership conference at SMS a success

About 50 SMS members participated in a June 9 Leadership Conference in Madison at SMS headquarters.

The conference provided in-depth discussions of the SMS court victory on the DHSS freeze on Medicaid payments, plus the premium reduction for the Wisconsin Health Care Liability Insurance Plan.

Also discussed was AB 784 (see separate story elsewhere in this section) which would severely limit the authority and scope of the State Medical Examining Board.

Dr Jordon Frank of Beloit reported that SMS negotiators are satisfied with the latest draft of the Title 19 Medicaid provider manual (see separate story). Doctor Frank stated that remaining items still to be negotiated include: (1) the level of reimbursement for physicians, and (2) the State's definition of what is "usual, customary, and reasonable." ■

★

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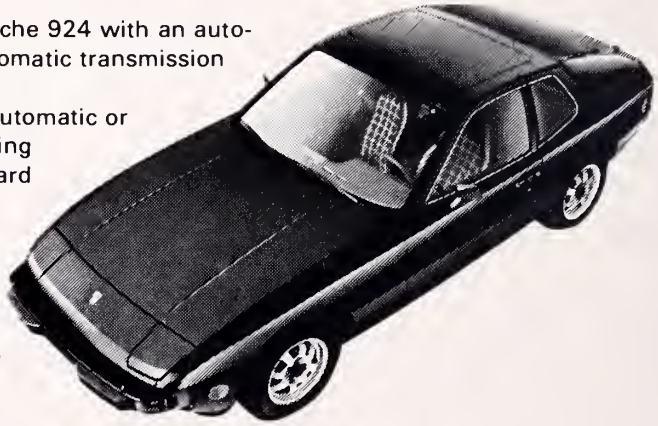

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MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report
as of May 13, 1977

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

BROWN

Calaguan, Raymundo R, 835 S Van Buren St, Green Bay 54305 (1938, Regular, Radiology/Nuclear Medicine)

Lin, Royce C, 2440 Brenner Pl, Green Bay 54301 (1936, Regular, Internal Medicine)

DANE

Echeverry, Alejandro, 2050 Allen Blvd, Apt 3, Middleton 53562 (1941, Resident, Neurological Surgery)

Gutcher, Gary R, 202 S Park St, Madison 53715 (1944, Regular, Pediatrics)

Kaufman, Paul L, 1300 University Ave, Madison 53706 (1943, Regular, Ophthalmology, Certified)

Tompkins, Bonnie M, 1300 University Ave, Madison 53706 (1942, Regular, Anesthesiology, Certified)

Woodford, John E, 1313 Fish Hatchery Rd, Madison 53715 (1943, Regular, Neurological Surgery)

MILWAUKEE

Barnes, Richard O, 6000 S 27th St, Milwaukee 53221 (1920, Regular, General Practice)

Becker, David L, 2040 W Wisconsin Ave, Milwaukee 53233 (1943, Regular, Orthopedic Surgery)

Evans-Gresch, E A, PO Box 512, Milwaukee 53201 (1936, Regular, Internal Medicine)

Hellman, Barry D, 2266 N Prospect Ave, Milwaukee 53202 (1946, Regular, Dermatology, Certified)

Kastelic, Robert, 3631 W Oklahoma Ave, Milwaukee 53215 (1932, Regular, Ophthalmology, Certified)

Marks, Norman S, 8700 W Wisconsin Ave, Milwaukee 53226 (1945, Resident, Urological Surgery)

Venci, Nicolas A B, 100 15th Ave, South Milwaukee 53172 (1944, Regular, Family Practice, Certified)

PRICE-TAYLOR

Schoenfeld, Paul M, Peterson Dr, Phillips 54555 (1948, Regular, General Practice)

PORTAGE

Jaeger, Robert J, 3291 Thompson Ct, Stevens Point 54481 (1943, Regular, Obstetrics and Gynecology)

WAUKESHA

Gruzynski, Thomas R, 2250 N 116th St, Wauwatosa 53226 (1944, Regular, Obstetrics and Gynecology)

Janowak, Michael C, 888 Thackary Trail, Oconomowoc 53066 (1947, Regular, Otorhinolaryngology)

WAUPACA

Peterson, Robert L, 710 Riverside Dr, Waupaca 54981 (1947, Regular, Family Practice, Certified)

WINNEBAGO

Van Dyke, David A, PO Box 115, Winnebago 54985 (1948, Regular, Psychiatry)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

MANITOWOC

Radl, Cyril J, Scottsdale, AZ, to 1425 N 9th St, Manitowoc 54220

MILWAUKEE

Casper, William T, Milwaukee, to PO Box 27, Green Valley, AZ 85614

Mahony, William M, Tinker AFB, OK, to 1225 Sunset Dr, Wausau 54401

Riabov, Sviatoslav N, Milwaukee, to PO Box 9, Newberry, MI 49868

SAUK

Booher, John A, Reedsburg, to 15312 50th Rd, Franksville 53126

WAUKESHA

Imse, David P, Delafield, to 123 Lawn St, Hartland 53029

WOOD

Garrison, Rogers E, Venice, FL, to 720 4th St, South, Wisconsin Rapids 54494

DEATHS

Nelson, Wallace L, Wood County, Dec 5, 1975

Delfs, Eleanor, Milwaukee County, Apr 2, 1977

Calvert, Charlotte J, Dane County, Apr 7, 1977

Buckley, William E, Racine County, Apr 30, 1977

Egan, William J, Milwaukee County, May 17, 1977 ■

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OBITUARIES

◈ County, State, AMA Members

◈ **Eleanor Delfs, MD,** 68, professor of obstetrics and vice-chairman of the Department of Gynecology and Obstetrics of the Medical College of Wisconsin, Milwaukee, died Apr 2, 1977 in Coral Gables, Fla. Born May 26, 1908 in Canfield, Ohio, Doctor Delfs graduated from Johns Hopkins School of Medicine in 1935. She served as president of the Milwaukee Gynecological Society in 1976.

Surviving are a sister, Mrs Douglas Gillette, Coral Gables, Fla, and a brother, Gilbert of Tombstone, Ariz.

◈ **Charlotte J Calvert, MD,** 76, Madison, died Apr 7, 1977 in Madison. Born June 30, 1900 in Benton, Doctor Calvert graduated from the University of Minnesota Medical School in 1925, and was the first woman intern at the University of Wisconsin Hospital in Madison.

Surviving are a son, Thomas of Madison; two daughters, Mrs James (Dr Charlotte A) Burns of Tuscon, Ariz, and Mrs Richard (Mary Ellen) Gibbs of Billings, Mont.

◈ **William E Buckley, MD,** 84, Racine, died Apr 30, 1977 in Racine. Born May 23, 1892 in Spring Valley, Doctor Buckley graduated from Marquette University School of Medicine in 1915. He practiced medicine in Red Granite until he opened an office in Racine in 1927. Doctor Buckley served as president of Racine County Medical Society in 1943 and retired from practice in 1975. Surviving is a son, William G Buckley, DDS of Racine.

◈ **William J Egan, MD,** 84, past Councilor and President of the State Medical Society, died May 17, 1977 in Milwaukee. Born Oct 30, 1892 in Hurley, Doctor Egan graduated from the University of Michigan Medical School in 1916. He served as a Councilor of the Society from 1959-1962 and again from 1964-1973. He was President of the State Medical Society in 1963-1964. Surviving are his widow, Elsie; two sons, William J and James F; and one daughter, Mrs Vi Candee. ■

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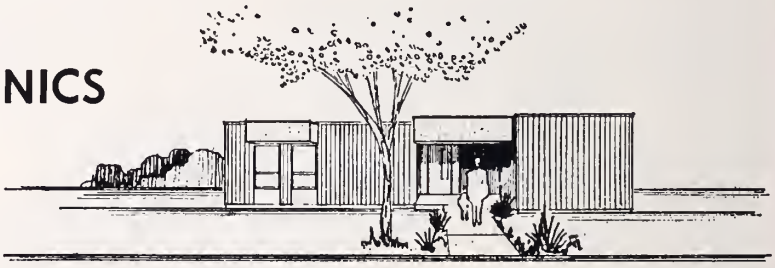

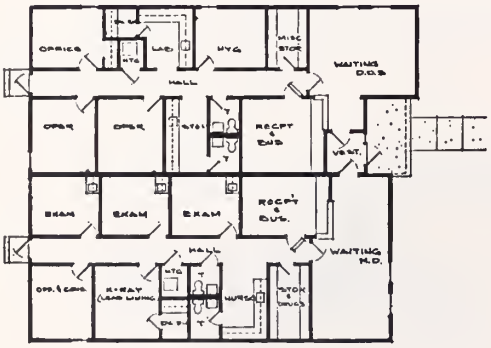

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Please see opposite page for Brief Summary.

The Mammography Dilemma

How to obtain high quality mammograms with the least amount of radiation and therefore the least risk for the patient is a major concern of physicians today.

In mammography many factors affect image quality and patient radiation exposure. Exposures approaching zero can be given. However, if the image isn't satisfactory, it will have little diagnostic value and the x-ray exposure, although small, will be unwarranted. This trade-off between image quality and dose lies at the heart of the problem faced by physicians.

A Mammography Monitoring by Mail (M^3) service provided by the Medical Physics Laboratories of the University of Wisconsin-Madison will supply TLD (thermoluminescent dosimetry) crystals which can be taped to a patient's skin during x-ray exposure to determine if equipment is working properly. Although designed for mammography studies, they also can be used to monitor other radiation equipment. Often more radiation is given than needed to obtain desired medical information. All physical parameters that determine if an x-ray unit can take satisfactory radiographic images can be measured and operators trained to use proper techniques to keep exposure at a minimum.

The recording system is important, because its speed is directly related to patient exposure. Advances in use of phosphor materials for radiographic intensifying screens have led to the development of faster screen and film combinations for mammography in order to reduce patient exposure, improve imaging geometry, reduce motion blur, and permit a wider range of technique choices.

Xeroradiography is an important imaging modality for early breast cancer detection. The edge enhancement inherent in the powder cloud development accentuates the low contrast structural information in the breast. The recording latitude allows the skin line, ducts, vascular structures, microcalcifications, and retromammary area to be recorded throughout the thickness of the breast in a single exposure.

Because of its greater recording latitude and ease and speed of interpretation, xeroradiography often is used by centers doing many mammography examinations; however, it is more costly with small volumes and more mechanically unreliable. It often gives slightly higher radiation exposure to patients, but this can be reduced by aluminum filtration of the incident x-ray beam; no decrease in diagnostic information has been observed with filtration up to 2.5 mm aluminum.

Negative mode xeroradiography, which has an exposure advantage over positive development of approximately 20% to 25%, is useful when a large density difference exists in the breast. Raul Matallana, MD of the Wisconsin Clinical Cancer Center says that by combining the positive and negative modalities of xeromammography, radiologists can correctly diagnose a lesion as benign in 98% of the cases or malignant in 95% of the cases.

Computerized tomographic mammography (CTM) may have potential, although conventional mammography appears superior for screening. Without using contrast material in CTM, many carcinomas are missed because areas of fibrous tissue may have the same density as carcinomas. With contrast material results are more comparable. It may increase the density of carcinomas to make them stand out more clearly. Spatial resolution with CTM is poor, so small calcifications cannot be detected. Hopefully, however, CTM will be useful in discovering tumors in dense breasts.

Mammograms are currently our best method for evaluating the female breast. Many physicians believe the benefits of mammographic examination far outweigh the risks for most women. Eight women out of 100 will probably develop breast cancer during their lives. Few cancers develop before age 35, so there is less need to screen young women. After age 35, a woman's chances of developing breast cancer increase.

Over half of the cancers are not detected on a physical examination without mammography. If radiation equipment is adjusted so a woman received less than one R radiation, her lifetime risk of developing cancer due to radiation will only be increased from 8% to 8.08%. Mammography is a useful screening method, especially in women over 50, who have a greater risk of developing cancer but less risk of developing cancer due to irradiation. It is recommended that women over 50 should have an annual routine mammogram, especially if they have any suspicious symptoms, a previous history of cancer, or a family history of breast cancer.

If a suspicious area is detected on a routine mammogram, it should be biopsied to determine if cancer is present. The greatest benefit is derived when the cancer is very small and treated early in its development when the chances are better for preventing its spread.

Dorothy J Buchanan-Davidson, PhD
Science Writer, WCCC

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

CANCER COLUMN

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American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS JULY 1977

"Climb Ev'ry Mountain"

The following is the acceptance speech of the newly elected President of AAMA Inc, Wisconsin Society, Dolores J Conlon, given at the Annual Meeting of AAMA Inc, Wisconsin Society, in East Troy, May 21, 1977.

THE THEME of our 1977 convention—"Climb Ev'ry Mountain"—befits all of us who belong to the American Association of Medical Assistants, Inc. At one time or another, each of us has faced our own personal Matterhorn or Alps. We are facing a new world of "how to's" and "do you know's." Are we capable of following the paths that will lead us through the mountains that lie before us?

Before our trek begins, preparations must be made. As we all know, our mental attitude must be strong and positive IF we are to follow the paths ahead . . . and *reach* our peak.

Looming bigger and more challenging just ahead is a fast growing profession—the Allied Health Field—offering new opportunities for the medical assistant. Truth is, as medical assistants, we have some of the most varied opportunities of any profession today. The list is growing, underscored by the expected realization of national health programming in the future. How we fit into the main stream depends on our outlook on life.

One of the most important factors in medical assisting is the human element. We cannot let our world of numbers, computers, and machines take over the human factor we all must have in order to give of ourselves. We must learn generosity . . . not in the sense of giving material things . . . but generosity in understanding, listening and loving, as it applies to patient care and service.

We also must learn and practice humility. Are our "pleases" and "thank you's" said in such a way that you and I deserve a "you're welcome?" We can not seek self-satisfaction while looking into the eyes of the terminal patient; nor while reassuring a mother whose white knuckles on folded hands give lie to the silent prayer that is crying out from the depths of her soul at her sick child's bed.

In a sense, we are like daisies in the field . . . the white petals depicting purity in our hearts to serve God and mankind . . . the yellow centers reflecting awareness of the concern for each other's needs . . . and the green leaves heralding eternal devotion to fulfilling our responsibilities in serving. As many of you here this evening have experienced, many are called to the health field but few are chosen for a career.

Speaking of careers, the United States government has projected that by 1985, approximately 20 million people will be employed in the Allied Health Field. Where will you and I fit into the picture? Will we have prepared ourselves to accept the 1985 concept of Allied Medical Assistance or will we still be in the sixties and seventies era? The American Association of Medical Assistants, Inc has given us the organizational vehicle in which to keep in step with the ever-changing medical field. But, the question still remains: where will we fall into the line—up front on the bandwagon or bringing up the rear where it will be too late to catch up?

Our physician-employers are required to fulfill a basic number of hours to keep in step with today's practice of medicine. There are many who fulfill these requirements threefold. Each of these physicians deserves a well-informed health team, one with which he can expand and use his knowledge to the peak of his capabilities. And we, as dedicated medical assistants, owe it to each and every patient whose lives we touch each day to keep in step with our physicians!

Education, however, can not be the only factor. Too often, the over-educated individuals forget the mechanics that are necessary in developing the profession. We have seen this happen in many fields selected by aspiring young people. At the time of seeking employment in their chosen field, the doors slam shut with remarks such as: "Sorry, you're too highly educated. We can't afford you." More than likely, you'll find them working in a completely different field of endeavor . . . putting their over-education to good use but not in their chosen career.

Once you are squared away in *any* profession, however, there's always a need for continued education programs. And, as you've been reminded so often, that's what AAMA seminars and symposiums are all about!

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But, over and above education and experience in our field, we have to make the most of another important tool, one which we have at our fingertips. That is, human relations! We must strengthen our ability to communicate with people, *not* just study *how* to do it. We must apply the magical forces of our own senses a step further—to *observe* rather than just see . . . to *listen* rather than just hear . . . to *apply tender loving professional care* rather than just touch.

As we face the challenge of the forthcoming years, let us rededicate ourselves by taking each other's hand to help climb that mountain of uncertainty together! Let each of you reap your personal harvest from that God-given valley that lies before it . . . carrying in your arms bundles of patience, generosity, understanding, trust and love. When you are asked to serve, be generous in heeding the call for help. Only through learning to give of ourselves can we learn to trust in receiving from each other.

As you leave this evening, think about the people in this room whose lives you may have touched, even in the slightest way. Did you, as a member of AAMA, impress them for the good of our society? Or have you created a bad impression by planting seeds of doubt?

Remember: we *all* carry the umbrella of AAMA! Preserve it . . . protect it . . . and, most of all, carry it proudly as we "Climb Ev'ry Mountain!" ■

WISCONSIN MEDICAL JOURNAL

Statement of Policy re Articles

The Editorial Board, with approval of the State Medical Society Council, in January 1975 established a new policy which limits to two pages articles published in the *Wisconsin Medical Journal*, except for such articles that may be deemed inappropriate for this policy by the Editorial Board. Should an article be longer than two printed pages, the author or other sources will be asked to subsidize the additional pages on the basis of $100 per page, with less than a page to be prorated. The intent of this policy is to accommodate more authors, broaden the subject matters, allow more flexibility to the Editorial Board in publishing articles that reflect current medical trends and development in Wisconsin medicine as they relate to the care of patients and the delivery of care, and to maintain the high standard of quality and production with fiscal responsibility.

Wisconsin Medical Alumni

. . . Association will be headed next year by a Green Bay physician, William E Hein, MD,* who is medical coordinator of St Mary's Hospital emergency department, Green Bay. He was named president-elect of the association at its 22nd annual Alumni Day meeting at the University of Wisconsin-Madison Medical School campus. He will take office as president next May.

Bernard H Kampschroer, MD, a Milwaukee radiologist, succeeded Hanno H Mayer, MD,* Milwaukee, as current president. Two directors also were elected: John K Hoyer, MD,* Rice Lake; and Burton Zimmerman, MD, Milwaukee. Both will serve three-year terms.

The association is comprised of over 5,000 physicians who received their medical training at UW-Madison or who were residents or interns at University Hospitals in Madison.

Edgerton Memorial Hospital

. . . held its 13th annual Visiting Professor Day, June 8. The visiting professor this year was Samuel M Cohen, MD, PhD, son of David A Cohen, MD,* Edgerton, who just returned from one year of research in Japan. His speech was entitled, "Potential Diagnostic Markers in Bladder Cancer."

UW Faculty Promotions

. . . at the Medical School in Madison recently were announced as follows: To professor—Frank H Attix, MS, radiology, also human oncology; Lorna S Benjamin, PhD, psychiatry; Neville Bittar, MD, medicine; John F Brugge, PhD, neurophysiology; Ronald L Engerman, PhD, ophthalmology; Stanley Goldfarb, MD, pathology; Ronald H Laessig, PhD, preventive medicine; Bernard Messert, MD, neurology; John H G Rankin, PhD, physiology, also gynecology-obstetrics; Thomas H Steele, MD, medicine; Leonard I Stein, MD, psychiatry; and Stuart J Updike, MD, medicine.

To associate professor—Gerald J Bargman, MD, pediatrics; Richard R Burgess, PhD, oncology; Allen W Clark, PhD, anatomy; William A Craig, MD, medicine; Catherine DeAngelis, MD, pediatrics; Don E Detmer, MD,* preventive medicine, also surgery; John F Fallon, PhD, anatomy; Norman C Fost, MD, pediatrics, also history of medicine; Alan S Gurman, PhD, psychiatry; John K Harting, PhD, anatomy; Donald B Nelson, BS, preventive medicine; Karen F Pridham, PhD, family medicine and practice, also nursing; and Ingolf H L Wallow, MD,* ophthalmology.

St Francis Hospital

. . . in Milwaukee is one of two hospitals participating in a pilot program that will test a new patient information system on hospital procedures. The program is intended to help the patient and his family psychologically prepare for the medical procedures and reduce patient anxiety. The system, called Tel-Hospital, is a companion to the nationally successful Tel-Med program in 85 cities. It was developed in response to the communication needs between doctor and patient and to position the patient as a member of the health care team rather than an object of hospital procedures. The purpose of Tel-Hospital is to supplement patient information in a uniform and consistent format. Utilizing the telephone, Tel-Hospital is a tape cartridge information library available to the patient upon the physician's request. St Paul-Ramsey Medical Center, St Paul, Minnesota, is the other hospital involved in the pilot program.

Kidney Transplants

. . . have increased in Wisconsin from 104 in 1975 to 130 in 1976, according to a report issued by the Marinette General Hospital communications department. "We know there has been medical advance in research and transplant procedures," explained John Kraus, MD* of the Boren Clinic, for the Kidney Foundation of Wisconsin, "but we sincerely feel that the Kidney Foundation 'gift to life' organ donor program played an integral part in this increase."

PHYSICIAN BRIEFS

Melvin F Huth, MD*

. . . Baraboo, recently was cited by the Sauk County Medical Society for his many years of service to the community and to the medical profession. He received a watch from his fellow physicians, presented by Society secretary Donald W Vangor, MD* of Baraboo. Doctor Huth recently completed his third consecutive three-year term on the Council of the State Medical Society, having completed the maximum allowable years in this capacity. He also is a member of the Editorial Board of the *Wisconsin Medical Journal.*

Doctors Huth and Vangor

Peter Midelfort, MD*

. . . Eau Claire, was recipient of the 1976 Medical Alumni Citation of the University of Wisconsin Medical Alumni Association when it met May 27 for Alumni Day on the Madison campus. He served his surgical residency at Wisconsin General Hospital from 1933-1937. Doctor Midelfort practiced at the Midelfort Clinic, Eau Claire, from 1939-1970. He was awarded the Alumni Association's Max Fox Preceptor Award in 1972 for his contributions to the teaching of medical students.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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UW Alumni Teaching Awards

. . . were presented to six doctors by the University of Wisconsin Medical School Alumni Association at its Alumni Day festivities May 27 on the Madison campus. Recipients are: Dr James Petterson, UW associate professor of anatomy, Basic Science Teaching Award; Dr William Craig, UW assistant professor of medicine, Clinical Teaching Award; and Dr Wayne R Kirkham,* fifth year resident in otolaryngology, Distinguished Teaching Award by a Resident. Award recipients from Medical School affiliated programs are: Dr Thomas F Nikolai,* specialist in internal medicine at the Marshfield Clinic; Dr Mischa Lustok,* Mt Sinai Hospital, Milwaukee; and Dr JoAnne A Selkurt,* LaCrosse pediatrician.

Medical College of Wisconsin

. . . Milwaukee, has announced the appointment of a new president who will take office September 1, 1977. He is Leonard W Cronkhite Jr, MD who will replace David Carley, PhD. Doctor Cronkhite is presently president of the Children's Hospital Medical Center in Boston, Mass. He is a 1950 graduate of Harvard Medical School where he also taught part-time and is now a lecturer in preventive medicine. He also is a consultant in medicine at Massachusetts General Hospital where he served his internship and residency in medicine. Doctor Cronkhite's particular interest is in preventive medicine which today is receiving greater attention in the medical community. Considered a man of strong administrative and leadership talents, Doctor Cronkhite's published articles show his sensitivity to present and future issues involving hospital administration, government regulation of medicine, and techniques for planning future health care delivery.

Doctor Cronkhite

Bellin Hospice

. . . a new approach to the terminally ill patient, has been approved by the State Division of Health, according to Ralph Andreano, Division Administrator. The hospice will be the first program of its kind in the nation, according to Bellin Hospital administrator Daniel Smith, because it will give equal emphasis to medical, nursing, and emotional care for paticnts and families.

Howard Young Medical Center

. . . in Woodruff was formally dedicated June 18-19 with national celebrities participating. Actress Elizabeth Taylor and her husband, John Warner, and Ralph Edwards of "This is Your Life" headlined the event.

Miss Taylor, niece of the late Howard Young, spent many summers in her childhood at her uncle's estate on Lake Minocqua. It was through the $20 million gift of Howard Young that the new 109-bed facility was made possible.

As MC Edwards recalled the beginnings of the medical complex when Dr Kate Newcomb arrived in the Northwoods by train in 1922. ■

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Michael S Garrity, MD*

. . . Prairie du Chien, has been promoted to clinical assistant professor of Family Medicine and Practice at the University of Wisconsin Medical School, Madison. He will continue his full-time practice at the Farrell Clinic in Prairie du Chien. The appointment stems from Doctor Garrity's involvement with the Medical School's rural practice rotation to train family physicians. He has been participating in this program since 1975; and in that time he has helped train 11 family physicians. One of them, Paul Schmidt, MD, completed his family practice residency in Madison in June and is setting up practice in Prairie du Chien. Also see separate story on the UW's residency training program.

Lawrence G Crowley, MD*

. . . dean of the University of Wisconsin Medical School, has been appointed acting vice-chancellor for health sciences of the UW-Madison. He succeeds Robert E Cooke, MD* who resigned to become president of the Medical College of Pennsylvania. He will be responsible for supervising the programs of the UW Medical School, School of Nursing, School of Allied Health Professions, Laboratory of Hygiene, University Psychiatric Institute, and University Hospitals. Doctor Crowley will continue as dean of the Medical School in addition to his new responsibilities. The Medical School graduates 130 new physicians each year and has a faculty of 800.

Kenneth E Lemmer, MD*

. . . Madison, University of Wisconsin Medical School emeritus professor of surgery, received the Emeritus Faculty Award of the UW Medical Alumni Association at its Alumni Day festivities May 27. Doctor Lemmer was on the UW faculty for 41 years, helped organize the medical alumni association, and was its first president in 1956.

James E Geigler, MD*

. . . Elm Grove, was honored by the Southeast Chapter of the Wisconsin Academy of Family Physicians upon completion of his year as president. He was presented with a gavel and plaque by the new president, Henry M Goldberg, MD,* Milwaukee.

Robert E Cooke, MD*

. . . vice-chancellor for health sciences, University of Wisconsin-Madison, effective July 1, assumed a new position as president of the Medical College of Pennsylvania. Doctor Cooke came to Wisconsin in 1973 from Johns Hopkins Hospital where he was pediatrician-in-chief.

George Lythcott, MD

. . . associate vice-chancellor for health sciences at the University of Wisconsin-Madison, has been appointed administrator of the federal Health Services Administration (HSA). The HSA has a $1.6 billion annual budget and overseas federal health programs for Indians, migrant workers, health maintenance organizations (HMOs), the federal leprosy hospital in Louisiana and eight hospitals for merchant seamen. An expert in international health, Doctor Lythcott headed a 20-nation team of medical experts in a worldwide smallpox erradication project from 1966 to 1969. A month ago he was named Edward Jenner Professor of International Medicine at the UW. Doctor Lythcott will take a three-year leave of absence from the school while holding the federal position.

Joseph M Lubitz, MD*

. . . Oconomowoc, in May was presented the Certificate of Appreciation for his service to education by the Friends and Alumni of the University of Wisconsin-Waukesha at their Founder's Day Dinner, May 12.

Joseph E Geenen, MD*

. . . Racine, recently was elected treasurer of the American Society for Gastrointestinal Endoscopy during its annual meeting in Toronto, Canada, May 26-27. Doctor Geenen is a clinical professor of medicine at the Medical College of Wisconsin, Milwaukee; director of the Digestive Disease Center at St Luke's Hospital in Racine; and in private practice at the Racine Medical Clinic, SC.

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Michael Kademian, MD

. . . University of Wisconsin-Madison instructor in radiation oncology, is leaving in July for several months of research and patient care at France's largest cancer hospital. Several private funds will pay for his fellowship at the Institut Gustave-Roussy in Villejuif, a Paris suburb. Support will be provided in part by an American Cancer Society Clinical Fellowship, a grant from the Ladish Foundation, Cudahy, Wisconsin, and University Radiotherapy Association Research and Development Funds.

John Brennan, MD

. . . LaCrosse, recently was appointed to the board of directors of the Wisconsin Medical Alumni Association. He is associated with St Francis Hospital, LaCrosse, in the emergency department. Doctor Brennan graduated from the University of Wisconsin Medical School in Madison, and served his residency at University Hospitals, Madison.

William Kelly, MD

. . . family practitioner, has joined the medical staff of the Birch Street Clinic, Park Falls. He graduated from the Medical College of Pennsylvania in 1976 and recently completed a rotating internship at the United States Public Health Service Hospital in Baltimore, Md.

George E Batayias, MD*
Julian E Ferstenfeld, MD

. . . Milwaukee physicians, recently were honored by admission to fellowship in the American College of Physicians.

Chiaw C Charavejasarn, MD*

. . . Neenah, recently was elected to fellowship in the American Academy of Allergy. A member of the Nicolet Clinic, Menasha, and Theda Clark Memorial Hospital, Neenah, Doctor Charavejasarn is a graduate of Siriraj Hospital, Faculty of Medicine, University of Medical Sciences, Bangkok, Thailand.

James W Koch, MD*
E Dolf Pfefferkorn, MD*

. . . Colby physicians who together have served the area for 42 years, recently were honored on "Doctors Appreciation Day." Doctor Koch graduated in 1950 from the University of Wisconsin Medical School, Madison and completed his internship at St Joseph's Hospital, Marshfield. Doctor Pfefferkorn also graduated from the University of Wisconsin Medical School, Madison, and received his internship training at St Joseph's Hospital, Marshfield.

Roy B Larsen, MD*

. . . president of the State Medical Society, was honored by the Marathon County Medical Society at a Sunday brunch at the Wausau Club following his installation at the SMS Annual Meeting, April 14-16, in Milwaukee. Doctor Larsen is the first Wausau doctor to be elected to the SMS presidency since Dr Joseph Smith held the office in 1925-1926.

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David Katz, MD*

. . . Eau Claire recently became a member of the consulting medical staff of the Barron Community Memorial Hospital and the Barron-Chetek Medical Clinics. Specializing in the practice of urology, Doctor Katz is associated with the Western Wisconsin Urology Service, Eau Claire, and is a member of the medical staff at Luther and Sacred Heart hospitals. He is a graduate of Jefferson Medical College, Philadelphia, Pa.

Jack C Manley, MD*

. . . Menomonee Falls, director of the cardiac rehabilitation program and exercise stress laboratory at St Luke's Hospital, received an "Outstanding Physician Award" from the American Heart Association/Wisconsin Affiliate.

John B McAndrew, MD*

. . . Oshkosh, recently was inducted as a fellow in the American Psychiatric Association. Doctor McAndrew is director of child-adolescent services at Winnebago Mental Health Institute and is a member of the council of the Wisconsin Psychiatric Association.

Gregory R Lochen, MD*

. . . Wauwatosa, recently became associated with Medical Eye Associates, SC, in Waukesha. A 1972 graduate from the University of Wisconsin Medical School, Madison, he served his internship at Blodgett Hospital, Grand Rapids, Mich, and his residency in ophthalmology at the Medical College of Wisconsin, Milwaukee.

Raymond Quandt, MD*

. . . Jefferson, recently was presented the "Outstanding Citizen Award." Doctor Quandt has practiced in Jefferson since his discharge from service in 1946. He has served as chief of the medical staff of all departments and is currently chief of the surgical department. Doctor Quandt also has been active in community affairs and is a past president, secretary and treasurer of the Jefferson County Medical Society.

John P Konsek, MD*

. . . and MDs John R Haselow* and Gay Anderson,* Neenah and Winneconne, are the new officers of the medical staff of Theda Clark Hospital in Neenah. They will serve as president, vice president, and secretary, respectively, for the next two years.

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for Wisconsin Physicians

Volumn VI, Number 4

July 1977

ACTIONS TAKEN TO REDUCE CLAIMS REJECTIONS

To improve service to physicians and subscribers, WPS regularly examines its claims processing operation. One of those areas monitored is claims rejections.

Each month WPS receives many claims for which it must refuse partial or complete payment. The reasons for these rejections include the following: services were not covered by the policy; charges were previously processed; the policy was cancelled before the service was rendered; the claim must be resubmitted on an appropriate claim form; and necessary information or claim form was not received when requested.

WPS is taking a number of steps to reduce these rejections.

For each action taken on a claim, whether paid in full or in part, whether partially or completely rejected, the subscriber receives an explanation through an Explanation of Benefits form, except for major medical claims. In addition, the EOB also indicates the provider (if payment is made to the provider) and recipient of service; the type, date and place of service; the amount billed and paid; and any deductibles taken.

WPS has periodically prepared literature for subscribers indicating the need for sending in the Explanation of Benefits form when submitting a claim under Medicare-PLUS coverage.

Personnel in WPS Inquiry Services urge subscribers, when they call with an inquiry, to read their policies thoroughly and to be aware of such important information as the effective date of coverage. By reading their policies, and calling or writing Inquiry Services for clarification on any points, subscribers can learn whether their coverage includes payment for emergency care, whether the medical care received must be provided to hospital inpatient to be eligible for payment, whether the policy covers dependents and whether the policy pays for routine physical examinations.

You can urge your patients to read their policies thoroughly and seek help when they have questions about their benefits. Placing the words "Patient Copy", or a similar indicator, on bills to patients can help reduce duplicate submission of claims.

While a rejected claim represents our efforts to accurately administer health insurance programs, WPS is making necessary efforts to reduce the number of rejected claims in order to make its operation more efficient.

Please bring to your Medical Assistant's attention the portion of "Report" relevant to their work.

If you have any suggestions or comments on "Report", send them to WPS Communications Division, 1717 West Broadway, Madison, Wisconsin, 53713.

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and their Medical Assistants

PHYSICIAN'S SERVICE REPORT

The **Physician's Service Report** is an important communication link between your office and WPS. Taking a moment to double-check the PSR can save important time and effort.

When supplying information on **diagnosis and Current Conditions**, select important phrases from the chart to describe the condition of the patient. Use such key words as vomiting, nausea, headache or dizziness when they apply. In emergency situations, where a fever is indicated, supply the temperature of the patient. (This information often makes a difference in our determination of payment.) If the patient has suffered an injury, indicate the date of the injury. (Some contracts have time limitations for the treatment of an injury.) Under all conditions, supply information under this heading which will help relate treatment with diagnosis, an important factor that determines whether a service is a covered benefit.

If you indicate **Procedure Code**, specify the code manual and place its title in a location easily seen by the WPS personnel processing the PSR.

When filling in **Description of Service**, please supply complete information. For services, describe exactly the service performed. For surgery, attach an operative report for any unusual or complicated (multiple) surgeries.

The services which often lack sufficient information are hospital visits, office calls and consultations.

If the patient is receiving medical care in a hospital, indicate whether the first day history and physical is *comprehensive, intermediate or brief/limited.* If the patient is receiving follow-up medical care as an inpatient, indicate whether the examination is *brief, limited, or extended.*

If the patient is receiving medical care in your office for a new condition, or if he is a new patient, indicate whether the visit is *brief, initial limited history and physical or initial comprehensive history and physical.*

If the patient is receiving continued medical care in your office for a condition which has been treated previously, indicate whether the examination is *brief, limited, intermediate or extended.*

If the patient is receiving a consultation service at a hospital, in your office or at home, indicate whether the consultation requires a *limited or more extensive consultation* or whether the examination requires a *comprehensive history and examination.*

Physician's Service Reports which must be corrected or supplied with additional information must be sent through the entire claims processing procedure again. Filling out the PSR completely and accurately helps WPS process claims efficiently and make payment to you quickly.

WPS

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 9, 1976.

1977 WISCONSIN

Aug 5-6: *Third Annual Sports Medicine Symposium,* Waunakee Public High School, Waunakee. See details elsewhere in this issue.

Aug 23-24-25-26: *Aging in Wisconsin.* One-day seminars at four locations: Madison (23), Eau Claire (24), Green Bay (25), and Milwaukee (26). Presented by Wisconsin Health Care Review Inc (WHCRI). Special interest to physicians, medical directors, nursing home administrators, directors of nursing, and consultant pharmacists. See details elsewhere in this issue.

Sep 10-11: *Academic Anesthesia: Fifty Years After* Conference, University of Wisconsin, Madison. Objectives: The appointment of Ralph M Waters, MD to the faculty of the University of Wisconsin in 1927 marked the beginning of a new era in anesthesiology. All sessions at Wisconsin Center. Conference fee: $27 for members of Wisconsin Society of Anesthesiology, $62 nonmembers. Info: CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

Sep 16-17: Dr Robert Shaffer, sponsored by Dept of Ophthalmology, University Hospitals, Madison.

Sep 21: *Green Bay One-day Seminar for Family Physicians,* at St Vincent Hospital. Further details later.

Oct 6-7: First meeting of Wisconsin Chapter of American College of Emergency Physicians, at Marc Plaza Hotel, Milwaukee. CME credit will be given. Further details will appear in the August issue.

Oct 7-8: *Geriatric Seminar: What's New for the Old.* Sponsored by Dept of Family Practice, Medical College of Wisconsin, and American Geriatrics Society. Mequon Care Center, Mequon (near Milwaukee). See details elsewhere in this issue.

AGING IN WISCONSIN
Seminars on Long-term Care

Wisconsin Health Care Review, Inc (WHCRI) will present statewide seminars focusing on the needs of residents in skilled nursing facilities:

Tuesday/Aug 23/Madison
Wednesday/Aug 24/Eau Claire
Thursday/Aug 25/Green Bay
Friday/Aug 26/Milwaukee

These one-day seminars will be of special interest to physicians, medical directors, nursing home administrators, directors of nursing, and consultant pharmacists.

Topics include:

- Alternate Care
- Psychological Needs of the Aged
- Drugs in the Long-term Care Facility
- Health-care Financing Administration and Its Relationship to Long-term Care
- Professional Judgment in Levels of Care Determination (Group Exercise)

Registration materials and further information may be obtained by contacting: WHCRI, 330 East Lakeside St, Madison, Wis 53715.

University of Wisconsin-Madison Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

CME Calendar—1977

Aug 10-12: *The Second International Meeting on Tryptophan Metabolism: Biochemistry, Pathology and Regulation,* Dr Ray Brown, Chairman, The Wisconsin Center, Madison. Fee: $70.

Aug 12-13: *Head and Neck Cancer,* The Park Motor Inn, Madison.

Aug 29-Sep 2: *Emergency Care Conference,* The Wisconsin Center, Madison.

Sep 7: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Sep 10-11: *50th Anniversary Anesthesiology Program,* The Wisconsin Center, Madison. Fee: Members $27; Nonmembers $62.

Sep 13: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Sep 15-17: *Family Physician Refresher Course,* The Edgewater Hotel, Madison. Fee: $125.

Sep 21: *Maternal and Infant Care: Infant Assessment and Early Management,* Beaver Dam Community Hospitals, Beaver Dam.

Sep 30-Oct 1: *Hospital Administration,* The University Bay Center, Madison.

Sep 30-Oct 1: *A Conference on Dermatology,* The Wisconsin Center, Madison.

Sep 30-Oct 1: *Trauma Symposium,* St Marys Hospital Medical Center, Madison.

Oct 11: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Oct 19: *Maternal and Infant Care: Special Neonatal Problems I,* Beaver Dam Community Hospitals, Beaver Dam.

Oct 25-28: *Educational Resources,* University Bay Center, Madison.

Oct 26-28: *50th Anniversary Preceptorship Program,* The Wisconsin Center, Madison

Nov 3: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Nov 3-5: *Interventional Radiology,* The Wisconsin Center, Madison.

Nov 8: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Nov 16: *Maternal and Infant Care: Special Neonatal Probblems II,* Beaver Dam Community Hospitals, Beaver Dam.

Info: Coordinator, Dept of CME, 601 Walnut Street, Madison, Wis 53706; phone: 608/263-2850.

1977 WISCONSIN

Oct 7-9: Wisconsin Radiological Society, Concourse Hotel, Madison.

Oct 19: *Green Bay One-day Seminar for Family Physicians,* at Bellin Memorial Hospital. Further details later.

Nov 16: *Green Bay One-day Seminar for Family Physicians,* at St Vincent Hospital. Further details later.

INTERSTATE SCIENTIFIC ASSEMBLY

Hollywood, Florida
Diplomat Hotel

October 31—November 1-3

This program is designed for Primary Care Physicians practicing in the United States and Canada. It has been planned cooperatively with the Florida Academy of Family Physicians, the University of Miami and the University of Florida-Gainesville. It provides 26 hours of credit for members of the American Academy of Family Physicians. Also credit toward the AMA Physician's Recognition Award is provided through attendance.

The program consists of lectures, informal group discussions, "live" closed-circuit TV and medical movies on a variety of topics with major emphasis on infectious diseases, endocrinology, cardiovascular, nephrology, nutrition, and rheumatology.

Guest lecturers include: Dr Irvine H Page of the Cleveland Clinic Foundation on "Science and Intuition in Medical Practice;" Dr Ray Gifford of the Cleveland Clinic Foundation on "Hypertension Update;" Dr Robert W Kistner of Harvard on "Major Gynecologic Problems Associated with Oral Contraceptives;" Dr Walter Spitzer of McGill University, Montreal, Quebec, on "A New Look at the Value of the Periodic Health Examination;" Dr Joseph Hollander of the University of Pennsylvania on "Diagnosis of Painful Joints."

In addition there will be numerous other lecturers from the University of Florida-Gainesville and the University of Miami. The Thursday session will be devoted to "Medical-Surgical Update."

The Assembly is open to any licensed physician in the US and Canada for a fee of $75 in advance or $100 at the meeting. Those interested in the meeting and hotel forms should write to: Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701.

1978 WISCONSIN

Jan 19-21: *Winter Refresher Course for Family Physicians.* Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians. Pfister Hotel and Tower, Milwaukee. See details elsewhere in this issue.

Mar 30-Apr 1: Second Annual Ophthalmology Current Concepts Seminar '78 of the University of Wisconsin-Madison. Lectures and Workshops. Sponsored by the Dept of Ophthalmology Faculty, University Hospitals, Madison.

1977 NEIGHBORING

Sep 26-30: *Family Practice Review and Update—1977,* a continuing medical education course sponsored by the University of Minnesota, Minneapolis, at the St Paul Radisson Hotel. This annual, five-day course is designed to meet the needs of physicians preparing for certification or recertification in family practice, or those wishing a comprehensive general review. All major fields of medicine and surgery are presented in a systematic manner. Fee: $245. Approved for approximately 40 perscribed hours by the AAFP and AMA Category 1 credit.
Info: Office of Continuing Medical Education, Box 293, Mayo Memorial Bldg, 420 Delaware St SE, Minneapolis, Minn 55455; (612) 373-8012.
g6-8/77

Sep 29-30: *Recent Advances in the Care of the Aging Patient,* a clinical program on geriatrics sponsored by the Illinois State Medical Society's Committee on Aging, in cooperation with the AMA, to be held in Oakbrook, Ill. Sessions are aimed primarily at the general internist, family physician, neurologist, surgeon or psychiatrist with a special interest in geriatrics. Tuition for the two-day program is $150. Info: Illinois SMS, 55 East Monroe St, Chicago, Ill 60603; (312) 782-1654.
g6-8/77

Oct 26-28: *Rights of children as research subjects* will be argued in a conference at the University of Illinois at Urbana-Champaign. Sessions to be held at Ramada Inn, Champaign. Info: Ronald

CONFERENCE ON ANESTHESIOLOGY

FIFTY YEARS AFTER—

September 10-11, Madison
University of Wisconsin

The appointment of Ralph M Waters, MD to the faculty of the University of Wisconsin in 1927 marked the beginning of a new era in anesthesiology. During his two decades at Wisconsin, Doctor Waters was the vitalizing influence for the rapid development of the specialty in the United States and abroad.

This meeting recognizes the resulting contributions of Doctor Waters and celebrates the Fifty Years of Academic Anesthesia at the University of Wisconsin and the United States.

In addition, the conference will explore how the specialty will be influenced in the future by changes in technology, pharmacology, and society at large.

All sessions will be held at the Wisconsin Center, 702 Langdon Street, Madison.

Conference fee of $27 for members of the Wisconsin Society of Anesthesiology covers all coffee breaks, lunch on Saturday, and the banquet Saturday evening.

Conference fee of $62 for nonmembers includes the educational program, all coffee breaks, lunch on Saturday, and the banquet Saturday evening.

Faculty will include:

Henry Bendixen, MD
Professor and Chairman, Department of Anesthesiology, College of Physicians and Surgeons, Columbia University, New York, New York.

Edmund I Eger II, MD
Professor of Anesthesiology, University of California, San Francisco, Calif.

E S Siker, MD
Past President, American Society of Anesthesiologists

Leroy Vandam, MD
Anesthetist-in-Chief, Peter Bent Brigham Hospital, and Professor of Anesthesiology, Harvard University, Boston, Mass.

Credit: All courses offered by the University of Wisconsin-Extension, Department of Continuing Medical Education, are accredited by the American Medical Association for Category I credit.

Sponsored by the Wisconsin Society of Anesthesiology and University of Wisconsin-Madison, Center for Health Sciences, Department of Anesthesiology, in cooperation with the Department of CME, Health Sciences Unit, UW-Extension

Info: CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

G Sears, Conference Director, 116 Illini Hall, University of Illinois, Champaign, Ill 61820. g6-9/77

1977 OTHERS

Aug 15-18: Fifth Western Hemisphere Nutrition Congress: *Nutrition in Transition,* in Quebec City, Canada, held under auspices of the American Medical Association, American Institute of Nutrition, Nutrition Society of Canada, Sociedad Latinoamericana de Nutricion, and American Society for Clinical Nutrition. Info: Dept of Foods and Nutrition, AMA, 535 North Dearborn St, Chicago, Ill 60610. g4-7/77

Sep 29-Oct 1: *National Conference on the Lymphomas and the Leukemias,* American Cancer Society—National Cancer Institute, Waldorf-Astoria Hotel, New York City. This CME offering meets the criteria for 15½ hours of credit in Category I for the PRA-AMA. Program is acceptable for 15½ elective hours by the AAFP. Info: Sidney L Arje, MD, American Cancer Society—National Cancer Institute, National Conference on the Lymphomas and the Leukemias, 777 Third Ave, New York, NY 10017. g4-8/77

Oct 17-22: *Eighth National Symposium and Workshop on Protecting the Abused, the Neglected, and the Sexually Exploited Child,* at the Sheraton Waikiki in Honolulu, Hawaii. Info: American Humane Association, Children's Division, PO Box 2788, Denver, Colo 80201. g7-9/77

Oct 31-Nov 1-3: *62nd Annual International Scientific Assembly of Interstate Postgraduate Medical Association,* at Diplomat Hotel in Hollywood, Fla. Further info: Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701. g6-9/77

Nov 4-5: *Conference on Cancer of the Bladder and Prostate,* American Cancer Society-Kentucky Division, at Stouffer's Inn, Louisville, Ky. Info: George A Sehlinger, MD, President, ACS-Kentucky Div, 2313 Medical Arts Bldg, Louisville, Ky 40217. g5-10/77

1977 AMA

Aug 8-13: "Medinfo '77"—2nd International Conference on Medical Computing, cosponsored by the Canadian Medical Association, International Federation for Information Processing; and World Health Association.

Aug 13-14: AMA Regional CME Meeting, cosponsored by Michigan State Medical Society, at Marquette, Mich.

Sep 16-18: AMA Regional CME Meeting, Tan-Tar-A Golf and Tennis Resort, Osage Beach, Mo.

Sep 30-Oct 2: AMA Regional CME Meeting, The Homestead, Hot Springs, Va.

Oct 7-9: AMA Regional CME Meeting, Sawmill Creek, Huron, Ohio.

THE FINANCING OF MEDICAL CARE

10th Annual Workshop of the Institute of Medicine of Chicago

Continental Plaza Hotel, Chicago

Friday, November 11

8:00 am to 5:00 pm

Are consumer health care demands realistic in terms of actual health care needs?

How Will Rising costs in the financing of health care affect undergraduate and graduate medical education?

Governmental, academic and private insurance company solutions to these problems will be subjects for panel and general discussion along with advantages and disadvantages of "capping" hospital payments and other means of cost containment in every phase of health care.

Registration ($45 for nonmembers, $40 for members) includes luncheon and coffee breaks.

For information, write Institute of Medicine of Chicago, 332 South Michigan Ave, Chicago, Ill 60604, or call 312/663-0040.

TRAUMA SYMPOSIUM

St Marys Hospital Medical Center Madison

September 30—October 1

in cooperation with University of Wisconsin-Madison Center for Health Sciences-School of Medicine and UW-Extension Health Sciences Unit, Dept of Continuing Medical Education.

Symposium co-chairmen: Louis C Bernhardt MD and James E Gutenberger MD, Dean Clinic and St Marys Hospital Medical Center.

Guest faculty: F William Blaisdell MD, Chief of Surgery Service, San Francisco General Hospital, San Francisco; Professor of Surgery, University of California School of Medicine; and Robert J Freeark MD, Professor and Chairman, Department of Surgery, Loyola University Medical Center, Maywood, Illinois

Faculty-UW Center for Health Sciences: Folkert O Belzer MD, Marvin L Birnbaum MD, and Dennis G Maki MD

Faculty-St Marys Medical Center: Louis C Bernhardt MD, Wojciech M Bogdanowicz MD, Richard J Botham MD, James E Gutenberger MD, Robert R Henderson MD, Ernest A Pellegrino MD, William Rock MD, George F Roggensack MD, J Michael Shannahan MD, Eugene E Skroch MD, George T Steinmetz MD, and Raul F Waters MD.

Fee: $50. *Credit:* AMA-PRA Category 1; AAFP applied for; CEHs by UW-Extension, Dept of CME.

Registration: CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

(Wisconsin-Northwestern Football Game, October 1)

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

August 8—September 4

Chronic Hemodialysis: Maximizing the Potentials
with Eli A Friedman, MD, Professor of Medicine, and Director of the Division of Renal Diseases, Downstate Medical Center, Brooklyn, New York

Assessing the Child with Acute Abdominal Pain
with Russell S Asnes, MD, Director, Pediatric Ambulatory Services, and Associate Professor of Clinical Pediatrics, Columbia Presbyterian Medical Center, New York City.

The Undergrown Infant: An American Problem
with Myron Winick, MD, Director of the Institute for Human Nutrition, the RR Williams Professor of Nutrition, and Professor of Pediatrics, Columbia University College of Physicians and Surgeons, New York City.

September 5—October 2

Clinical Immunology Update
—The Mechanisms of Immune Competence
—Immune Deficiency Disorders
—Autoimmune Diseases

The telecourse faculty on this three-part program is Robert M Nakamura MD, Chairman, Department of Pathology, Scripps Clinic Medical Institutions, La Jolla, California and Ernest S Tucker MD, Associate Clinical Professor of Pathology and Pediatrics, University of California School of Medicine, San Diego.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in most videotape and videocassette formats.

NATIONAL JAIL CONFERENCE

American Medical Association

August 21-22, Milwaukee

Marc Plaza Hotel

Program:

—Overview of the AMA jail project

—Why jail standards?—View of the ombudsman and the inmate

—Mental health intervention for jail inmates: how to do it

—Medicolegal issues and viewpoints from: jail medical directors, expert witnesses, the lawyer, jail physicians, county commissioners, and more

For details, contact: AMA Jail Project, 535 North Dearborn St, Chicago, Ill 60610.

Medical College of Wisconsin CME Courses in Milwaukee

* * *

GERIATRIC SEMINAR
What's New for the Old

Friday-Saturday/October 7-8
Mequon Care Center/Mequon (near Milwaukee)

One and one-half days. AMA Credit, 10 hours; AAFP Credit, 10 Hours. Fee: $90.

Course director: Donald J Welter, MD, Professor and Chairman, Dept of Family Practice, MCW.

Sponsored by: Dept of Family Practice, Medical College of Wisconsin, and American Geriatrics Society.

* * *

Winter Refresher Course for Family Physicians

Thurs-Fri-Sat/Jan 19-20-21, 1978
Pfister Hotel & Tower/Milwaukee
Two and one-half days. AMA Physician's Recognition Award, 16-18 credit hours. AAFP, 16-18 credit hours.

Course director: Thomas F Garland, MD, Associate Professor of Family Practice, and Program Director, Family Practice Residency Program, Deaconess Hospital.
Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians.

* * *

Further details: Dept of Family Practice, MCW, 610 North 19th St, Milwaukee, Wis 53233.

THIRD ANNUAL SPORTS MEDICINE SYMPOSIUM

Friday-Saturday/August 5-6
Waunakee Public High School
(near Madison)

Designed for coaches, trainers, physical therapists, physicians, and interested parents.

Faculty will include Doctor James Andrews, Team Orthopedist, Auburn University; Doctor Merrill Ritter, Team Orthopedist, Indiana University; Doctor William Clancy, Team Orthopedist, University of Wisconsin; et al.

A separate physicians' program will be presented. Fee: $50 for physicians, $20 all others. Fee includes tuition, materials, breaks, lunch on Saturday and dinner Friday evening.

Accredited by AMA for Category 1 and University of Wisconsin-Extension for Continuing Education Hours.

For further information, write or call Dennis M Day, 456 WARF, 610 N Walnut St, Madison, Wis 53706; (608) 263-2860.

1977 AMA

Oct 30-Nov 4: AMA Regional CME Meeting, Honolulu, Hawaii.

Nov 10-11: AMA 16th National Conference on Physicians and Schools, Regency Chicago, Chicago.

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Dec 20-23: AMA National Leadership Conference.

Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

CONTRIBUTIONS—CES FOUNDATION
May 1977

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for May 1977.

Unrestricted

Vanna M Klees, MD; Thomas C Nolasco, MD—*Voluntary contributions*

Restricted

State Medical Society Wisconsin Auxiliary—*In Honor of Chet Bradley and Justice Shirley Abrahamson*

Doctors Clinic of Wisconsin Rapids; LJ Seward, MD; Community Medical Group-Mondovi; RM Nesemann, MD; Robert L Hendrickson, MD; Elmbrook Memorial Hospital-Brookfield; Richard J O'Malley, MD; Apple River Valley Memorial Hospital-Amery; Family Medical Clinic-Merrill; Robert D Heinen, MD; Medical Association of Menomonee Falls —*Medical Student Summer Externship Program*

Marathon County Medical Society Auxiliary—*Marathon County Medical Auxiliary Loan Fund*

Membership Dues—*Aesculapian Society*

Memorials

Mr-Mrs Bill Reinhardt—*Martin Statz (Student Loan Fund)*

Dr-Mrs Robert T Schmidt—*Joseph Hoida; Roger Daoust; Anna Nockerts; Colonel Edward T Burrall (Brown County Loan Fund)*

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AMA Points the Way to Learning and Leisure

CME Sites Are Quite a Sight!

Enjoy a picturesque change of pace while you earn postgraduate credits! In 1977, the AMA is holding four of its 15 Continuing Medical Education Meetings at some of America's most beautiful resorts. Morning hours are devoted to study, and afternoons are reserved for your favorite recreational pursuits. Depending on the facilities available, you can play a round of golf or several sets of tennis, go boating or fishing, swim, surf, or go horseback riding. Choose from these scenic settings:

Tan-Tar-A Golf and Tennis Resort
Osage Beach, Missouri
Sept. 16-18

Sawmill Creek
Huron, Ohio
Oct. 7-9

The Homestead
Hot Springs, Virginia
Sept. 30-Oct. 2

Sheraton-Waikiki
Honolulu, Hawaii
Oct. 30-Nov. 4

FOR FURTHER INFORMATION, SEND IN THIS COUPON!

CME

Dept. of Meeting Services
American Medical Association
535 N. Dearborn
Chicago, IL 60610

Please send me further details on the AMA CME Meetings in:

☐ Osage Beach ☐ Huron
☐ Hot Springs ☐ Honolulu

Name _____

Address _____

City State Zip _____

MIGRANT WORKERS AND OTHERS MAY BE ELIGIBLE FOR MEDICAL HELP

Ralph Andreano, PhD, administrator of the State Division of Health, has advised Wisconsin physicians of the following information: "Occasionally poor persons, including migrants, entering hospitals are not covered by Medicaid or Medicare. Such individuals may be eligible for medical help under the general relief program operated by counties or municipalities within the county. Ordinarily hospitals receive prior authorization from relief officials to assure payment for care. However, this is not always possible and 49.02(5) Wisconsin Statutes provides for municipalities or county liability for eligible persons 'when, in the reasonable opinion of a physician, immediate and indispensable care or hospitalization is required, and prior authorization therefore cannot be obtained without delay likely to injure the patient.' Further, 'There shall be no liability for such care or hospitalization beyond what is reasonably required by the circumstances of the case, and liability shall not attach unless, within seven days after furnishing the first care of hospitalization of the patient, written notice by the attending physician and by the hospital be mailed or delivered, to the official or agency designated in accordance with this section, reciting the name and address of the patient, so far as known, and the nature of the illness or injury, and the probable duration of necessary treatment and hospitalization.' If the municipality or county refuses to pay for the care, the hospital may initiate a suit to force payment. Section 49.02(1) provides that municipalities 'shall furnish relief only to all eligible dependent persons therein . . .' and Section 49.02(2) provides that 'Every county may furnish relief only to all eligible dependent persons within the county . . .' The municipality or county granting such relief may find that the cost is the responsibility of another unit of government and make collection under Section 49.11. Collection from another unit of government or for State dependents is the responsibility of the municipality or county."

SEMINARS SLATED ON LONG-TERM CARE

Four statewide seminars, scheduled for August, will focus on the needs of residents in skilled nursing home facilities. Sponsored by Wisconsin Health Care Review, Inc (WHCRI), the one-day seminars should be of interest to physicians, medical directors, nursing home administrators, and consultant pharmacists. The seminars are slated for Madison, Tuesday, August 23; Eau Claire, Wednesday, August 24; Green Bay, Thursday, August 25; and Milwaukee, Friday, August 26. Topics to be discussed include alternate care, psychological needs of the aged, drugs in the long-term care facility, health-care financing administration and its relationship to long-term care, and professional judgment in levels of care determination. For additional information contact WHCRI at Box 1109, Madison, Wis 53701.

MEDICAID FREEZE ENDED JUNE 30

Negotiators for the State Medical Society and the State Department of Health and Social Services reached agreement in June that the Medicaid freeze on physicians' fees be ended June 30, 1977. Physicians' services provided after July 1 will be reimbursed at the doctor's actual charge or the newly updated 1977-1978 *Medicare reasonable charge rate* (RCR), whichever is lesser. This is the *maximum allowable cost* (MAC) under federal law. The successful end to the fee negotiations came just three weeks after Dane County Circuit Court Judge P Charles Jones upheld the Society's lawsuit against the freeze, which originally was imposed by the now-departed Governor Patrick J Lucey.

DON'T FORGET THE IRELAND TRIP!

Reservations continue to be made by Wisconson physicians who will participate in the SMS-sponsored trip to Ireland this fall. The trip begins Monday, September 5, from Milwaukee, with travelers returning Tuesday, September 13. Physicians who want more information about the trip may contact the travel agency handling arrangements: Dittman Tours, Inc, PO Box 199, Northfield, Minn 55057. ■

CERTIFICATE-OF-NEED PROGRAM BEGAN JUNE 30

Physicians are reminded that as of June 30, 1977 the provisions in the health facilities, services, and equipment "certificate-of-need" program apply to them and their purchases of clinical equipment. The program requires any physician who intends to purchase any single piece of equipment costing more than $100,000 or any two or more pieces of equipment costing more than $150,000 must receive prior approval for the purchase or face financial penalties.

Under the law, any physician who has signed a contract for the purchase of equipment covered under this law, prior to June 30, 1977, is exempt from the certificate-of-need process. However, any physician who has signed a contract for covered equipment after June 30 is subject to penalties. In this case the physician must contact the State Medical Society immediately and complete a certificate-of-need application. If the physician fails to do this, he may face possible rejection of the purchase.

Finally, if any physician intends to sign a contract for covered equipment in the near future, he or she is urged to withhold that obligation until the State Department of Health and Social Services completes its development of application forms and procedures. The Department expects to mail this information to all physicians' offices, county medical society presidents, and Health Systems Agencies (HSAs) by August 15.

Currently DHSS is considering conducting workshops on the certificate-of-need process for physicians and/or clinic managers. The State Medical Society will contact physicians in regard to such plans. Physicians with questions concerning the certificate-of-need program should contact the SMS Physicians Alliance staff at 608/257-6781.

REPORT ON HYPERTENSION TREATMENT NOW AVAILABLE

Physicians can now obtain the latest findings on the treatment, management, and education of hypertensive patients in a report recently put out by representatives of major medical associations See further details in the LETTERS section of this issue.

NHI HEARING SPEAKERS CALLED FOR PSROs TO RELEASE INFO

At the August hearings in Madison and Marshfield of President Carter's Advisory Committee on National Health Insurance, many speakers argued that "the time has long passed when the data on individual practitioners and institutions can be concealed," and called on PSROs to release the full range of information "without infringing on the patient's privacy." Only one person reminded the audience that patients have profiles, too, and some of those might bear scrutiny as to reason and cost. Further details of the hearings appear eslswhere in this issue.

SUPREME COURT RULES ON PROFESSIONAL ADVERTISING

A recent ruling by the US Supreme Court regarding advertising by two Arizona lawyers now strikes down state laws against professional advertising. The Court's ruling that "advertising of routine legal services cannot be constitutionally prohibited" sheds new light on the physician advertising question. Justice Harry A Blackmun, stating the majority opinion in the 5-4 ruling made it clear, however, that this only applies to brief advertising statements of fees for specific routine services. Advertising that is false, deceptive, or misleading is prohibited as well as self-laudatory statements and open solicitation of consumers. The Court's opinion closely parallels the AMA Judicial Council's "Statement on Advertising and Solicitation," which appears elsewhere in this issue. ■

the wisconsin medical journal

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LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701. Ph: 608/257-6781.

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State Medical Society of Wisconsin

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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The usual and customary fee

RELATIVE VALUE scales and reimbursement by insurance carriers according to "usual and customary charges" have in some states been judged to be a form of price-fixing. For that and other reasons, this may be the time to drop that method of payment.

Prior to the development of relative value payment schemes, physicians were paid by insurance companies according to set fee schedules for their services; for instance, a cholecystectomy was worth $300, appendectomy $200 and so forth, regardless of where it was performed. The figure, whatever it was, was not changed until the contract came up for renewal, and because of that the insurance company was better able to project its costs for that period. Nowadays the "usual and customary" relative value factor is likely to be changed at unpredictable times depending upon inflation trends. This can catch insurance carriers without sufficient reserves.

"Usual and customary" is really not indicative of what is usual and customary anyway. What happens is that the word is passed along that a certain procedure is now worth up to a certain maximum in a certain region, and that amount automatically becomes the going rate. A set published fee schedule furnished to all subscribers on enrollment is more conducive to preoperative discussion between patient and surgeon at the time of the initial consultation. The prospective patient will know that his insurance company pays a certain maximum amount for an operation and that this is likely to be somewhat below the usual charge for that procedure by a surgeon of considerable skill and experience. The patient will expect to be billed for the balance and won't be getting a letter from the insurance carrier stating that the surgeon's bill was more than the amount allowed.

Furthermore, if "usual and customary" were abolished, insurance companies would be subject to less pressure from well-organized specialty groups, each of which can present all sorts of reasons why its "usual and customary" charges should be raised. With fixed fee schedules the specialty groups can still decide what their fees should be, but the insurance company can react as it wishes and can sell its contract accordingly. The patient can simply pay whatever difference there might be, or shop around if he so chooses. Nothing could make the consumer advocates happier.—WJB ■

Medical necessity program ill-advised

THE MEDICAL Necessity Program announced by the Blue Shield Association last May has excited less comment than might have been expected. (The program proscribes automatic payment for 28 procedures considered to be outmoded or of questionable benefit. Payment will not be made unless the performance of the procedures can be supported in writing by the physician.)

An example of outmoded surgery most often cited by Blue Shield is that of uterine suspension; and among federal employee subscribers alone, they figure to save 3.9 million dollars annually, if that operation is no longer paid for.

But Blue Shield overlooks a simple truth: any one who can suspend a uterus can learn to remove one, and that pays even better.

Surgeons who are looking for operations to perform will always be able to find them as long as the public continues to feel a need to be operated upon, and no insurance company will ever change that. Of those patients of mine who are told they don't need an operation, as many walk away disappointed as relieved; and I am sure the disappointed ones keep looking until they find a surgeon who concurs with their self-diagnosis and plan of therapy.

There is behind all this, however, a bothersome concept: that an insurance company can decide what is proper treatment and what is not. That is ultimately a much greater threat to the public than a knife-happy surgeon. Unethical physicians are finding it harder and harder to retain hospital privileges and membership in their peer groups as their work is subject to greater and greater scrutiny. Can an insurance company be dealt with as easily?

Editorial Director—WAYNE J BOULANGER, MD, Milwaukee

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It might be wise to insist now that hospital tissue and peer review committees retain the right to decide what therapy is outmoded and what is not, and to insist as well that insurance companies retain their responsibilities of processing claims and paying off according to their contracts with subscribers.—WJB

Dealing with bureaucrats

As GOVERNMENT involvement in health-care delivery increases, bureaucrats play an ever-increasing role in day-to-day relationships with physicians. Some of us received our baptism in this sort of relationship as we developed our local PSROs. The following tips based on that painful experience may be useful to those of you who find yourselves caught up in a project in which government has an interest:

1—Don't be innovative. You'll be encouraged unofficially; but if you flop, you'll stand alone. If you succeed the Bureau will take the credit.

2—Don't volunteer. There must be an even bigger sucker than you who is willing to be part of a pilot project. Funding is just too uncertain.

3—Keep in mind that deadlines never apply to the Bureau—only to you. Sometimes the announcement of the deadline may arrive after the deadline has passed, particularly if a weekend or holiday intervenes or the Postal Service has been employed to transmit the information.

4—Remember that the regulations interpreting a state or federal law as promulgated by the Bureau may bear little resemblance to the law itself but instead may tend to reflect the Secretary's or his designee's personal bias. These regulations, if allowed to go unchallenged, can have the effect of law in time. If you feel the Bureau is misinterpreting the law, stand up and fight when you think you're right. You might be surprised at the results.

5—Do not accept any telephonic authorization from the Bureau as official approval. Get it in writing.

6—Never, *but never,* spend any of your own money. You will never get it back. Don't even spend any of your money after you have seen the figure budgeted by the Bureau for the use of your organization. There may be late cutbacks in funding. Get the money first, then move quickly.

7—If the money does materialize, spend it all. Otherwise next year you'll get less.

8—Be prepared to change direction overnight. The Secretary is almost certain to be replaced in a month or two by a former speech writer with an entirely different concept of the function of the Bureau, and you'll have to start all over from scratch.

9—Somewhere out there, there is a congressman who is as irked with the Bureau as you; work with him. He can help.—WJB

* * *

(The reader also is advised that the State Medical Society often is easier to reach and quicker to provide help than the congressman.)

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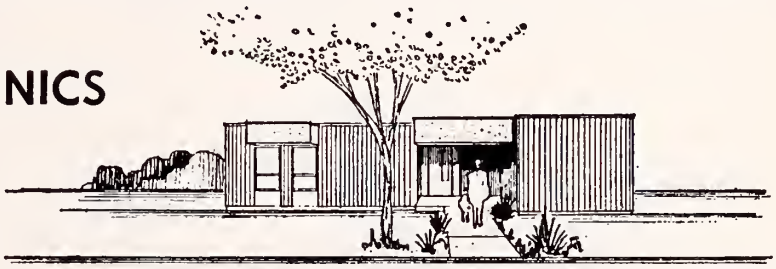

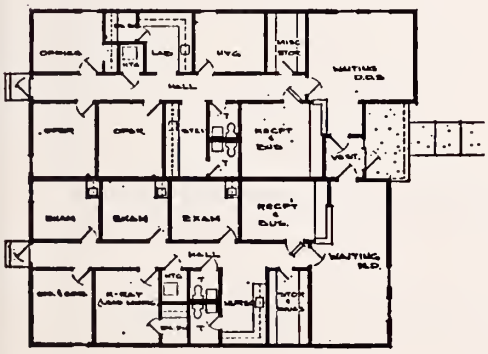

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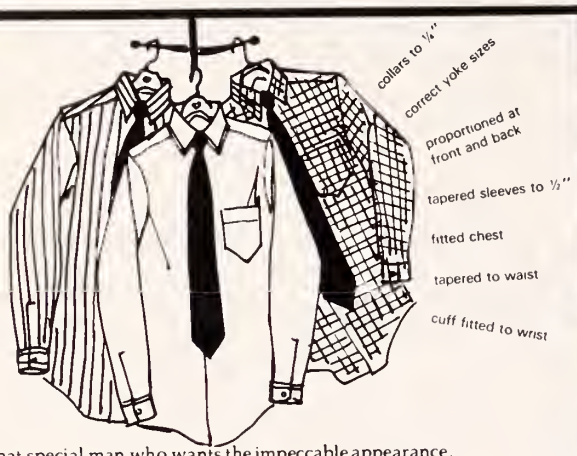

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Hijacked bed

RECENTLY AN English housewife established squatter's rights in a hospital bed. She had suffered from cholelithiasis for 18 months and had been told she would have to wait at least a year for an operation under Britain's free national health service. She cut the red tape by simply climbing into an empty bed and refusing to move out of it until she had her operation.

Twenty years ago a group of Wisconsin surgeons was touring Scandinavian hospitals. Since Norway, Sweden, and Denmark also have national health service, the Wisconsin surgeons were told of the horrendous backlogs of patients awaiting elective surgery. Even then the average wait for a cholecystectomy was at least 18 months. Of course, during that prolonged wait, additional problems such as acute cholecystitis or common duct stones commonly arose. Thus, the patients' convalescences were two to three times as long as they would have been if they could have had the surgery done promptly. Consequently the problem compounded itself as the hospital beds were tied up longer and the waiting list became greater.

How well would some of your impatient patients tolerate a wait,of 12 to 18 months to part with their troublesome gallstones? This is another beautiful example of the disadvantages of national health service.

—VSF

Borborygmus

IN THE JULY ISSUE of the *Wisconsin Medical Journal* there appeared an editorial entitled "On Intestinal Fortitude." Almost concurrently several indications of intestinal rumbling (always music to the clinicians' ears) became audible.

The first of these came from the AMA meeting in San Francisco, and the statistics compiled by the AMA from 47 states showed that the number of disciplinary actions against physicians had tripled in the past five years. In 15 states which had enacted legislation in making the reporting a professional malpractice mandatory, the number of investigations initiated by the state medical disciplinary boards had increased sixfold. Doctor James Sammons, executive vice-president of the AMA, pointed out that medical societies have no disciplinary authority other than to censure membership, which doesn't stop the doctor from practicing medicine, and that more stringent discipline is handled by the state medical licensing board in each state.

In the June issue of the Bulletin of the American College of Surgeons disciplinary actions for the years 1976-1977 were listed. The performance of itinerant surgery by a Wisconsin surgeon resulted in his Fellowship being placed on probation. Another surgeon in Wisconsin was placed on indefinite suspension for surgical incompetence. Another surgeon from Wisconsin who had been found to be performing itinerant surgery

was removed from censure because he had discontinued the activity.

Probably most significant was the public report on board activities in the newsletter from the Wisconsin Medical Examining Board also published in June 1977. This report noted that until 1976 Wisconsin had what was probably the weakest Medical Practice Act in the country. The Medical Examining Board, with assistance from the State Medical Society, sought and obtained a complete revision of this act. Since the law was enacted in July 1976, the Board has vigorously exercised authority to investigate and discipline its licensees while working within the limits of the state legal system and carefully observing the requirements of due process. The report further states that since October 1976, the Board has revoked four licenses and suspended one. The formal hearing processes have been completed in three more cases, and final disciplinary action is pending. In addition, two other physicians have surrendered their licenses rather than face board action. Altogether in the past year the Board has begun investigation in 226 cases although half of these have shown no basis for disciplinary action.

Policing one's own profession is a difficult and onerous task, but there certainly appears to be progress in the intestinal fortitude department. — VSF ▪

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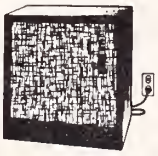

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School-hospital affiliations

To the Editor: Enclosed is an abstraction of an article I wrote in *Hospital Practice* (School-hospital affiliations: a balancing of interests). In view of the current activities of both medical schools in Wisconsin with community hospitals, I would be interested in reactions to the concepts I have discussed. (The abstract appears on page S/105 of this issue.)

BURTON A WAISBREN, MD
700 North Water Street
Milwaukee, Wisconsin 53202
(Tel: 414/272-1929)

July 14, 1977

The term "cure" and what it means

To the Editor: I deplore the term "cure" (Chemosurgery for Melanoma, Abstracts, May 1977, *Wisconsin Medical Journal)* when applied to melanoma, or for that matter, to any malignancy. Mention is made of a five-year cure rate. Be it five years, ten years, or twenty years—these are survival rates.

The term "cure" when dealing with malignancies is as frivolous as the claims made by Laetrile proponents. The tobacco grower uses the term "cure" properly when applied to a shed of tobacco leaf.

R W STEUBE, MD
540 Port Side Dr
Naples, Florida 33940

June 13, 1977

To the Editor: The term "five-year cure rate" is very well understood to mean that the patients were free of evidence of cancer at five years. The trouble with the term "five-year survival" is that it only indicates that the patient survived for five years. It fails to indicate whether or not the patient is free of cancer at that time. Hence, it is a less precise term.

FREDERIC E MOHS, MD
University Hospitals
1300 University Avenue
Madison, Wisconsin 53706

August 16, 1977

(EDITOR'S NOTE: The summer 1977 issue of *Cancer News* published an article by Dr C Gordon Zubrod, Director of the Comprehensive Cancer Center of Greater Miami and former Clinical Director of the National Cancer Institute. His answer to the question "What does 'cured' mean?" was: "Patients generally are considered cured if they are symptom-free five years after treatment, when they can enjoy normal life expectancy.")

Biting insect summary

To the Editor: Again this year I am compiling a Biting Insect Summary and would appreciate any case reports of unusual allergic reactions, especially systemic (sneezing, wheezing, urticaria) to bites of insects; *ie,* mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc.

I would like physicians to supply me with case reports of those patients who have had unusual reactions to such insects. Include in your reports the type of reactions (immediate and delayed symptoms), treatment, the age, sex, and race of the patient, the site of the bite(s), the season of the year, and any other associated allergies.

If skin tests and hyposensitization were instituted, I would like the report of both. Please note that it is the biting (not stinging) insect in which I am interested.

If you have found any insect repellant, local treatment, or insecticides of value, I would appreciate this also.

Please send this information to the following address:

CLAUDE A FRAZIER, MD
4-C Doctors Park
Asheville, NC 28801

June 17, 1977

High Blood Pressure Report

To the Editor: Physicians across the country have long felt the need for greater clarity in the approach to the treatment of high blood pressure and for guidance in the management and the education of hypertensive patients. The Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure answers these needs. This Report marks the first time representatives of major medical associations have reached a consensus on hypertension management.

One of the most important features of this Report is its simple, economic approach to diagnosis and treatment. Blood pressures are specified as requiring further investigation, periodic followup, or treatment. Updated guidelines for therapy have been formulated. The Report presents a pharmacologic rationale for the "stepped-care" approach to therapy. The Report also offers guidance in increasing compliance through patient education and through approaches to patient management.

Copies of the Joint National Committee Report are available now and may be ordered from the High Blood Pressure Information Center, 120/80 National Institutes of Health, Bethesda, Md 20014.

GRAHAM W WARD
Program Coordinator
National High Blood Pressure
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August 1, 1977

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin.

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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Wisconsin leaders talk about health care

To identify the perspective role of medicine in the health of Wisconsin citizens, the State Medical Society's Communications Department has initiated a series of interviews with prominent leaders in the state. The following interview with Ralph Andreano, PhD is the first in a series. An economist and administrator of the Wisconsin Division of Health, Doctor Andreano perhaps has more influence on health-care policy in Wisconsin than any other single person.

Q. What general trends and occurrences do you see happening in coming years to hold down the cost of health care for the average citizen?

A. The conventional methods (I should say conventional because nobody really knows what's going to work), the strategy that seems to be emerging for cost containment, are built around the local planning agencies; that is to say Public Law 93-641, with prospective rate review for hospitals and the certificate-of-need concept, remains to be seen. I think by and large what one foresees in the future with respect to costs is that there's no stopping them. It's difficult for me to see that even with better planning, with much more sophisticated regulation of new capital, and with prospective rate setting for inpatient hospital care and outpatient hospital care, these surely will have some impact.

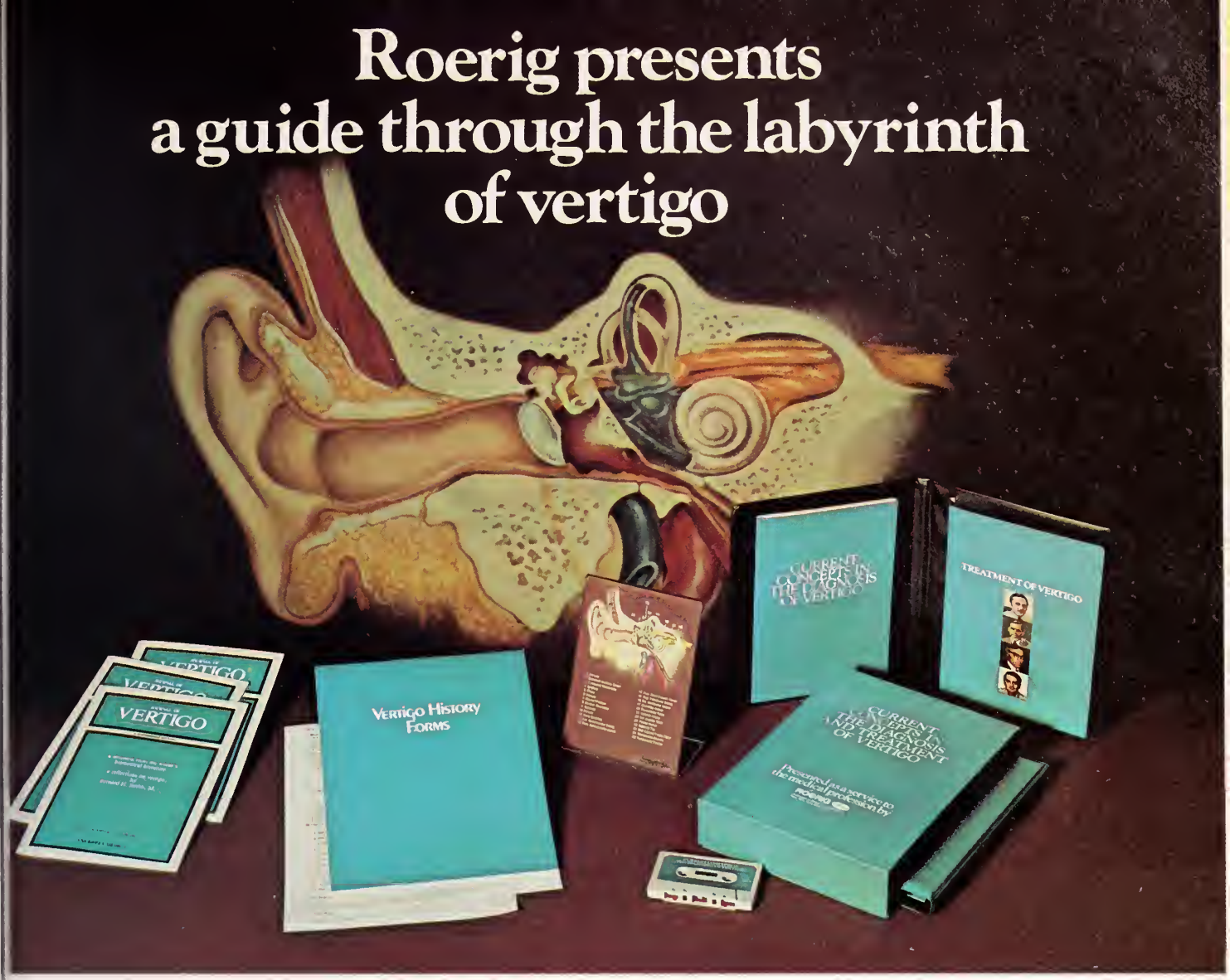
I think the basic equation and what constitutes the pressures for rising health-care costs to the individual citizen are his own perceptions of what he wants out of the health-care system, the insurance system under which we operate, and the extent to which individuals undertake responsibility for their own health. As you know, most of the scientific evidence we have shows that if you look at the leading causes of mortality and morbidity and you ask how much reduction could take place in mortality and morbidity from say the conventional or traditional health-care system as opposed to some alternative things like genetics, biology, environment, and the like, you easily conclude that the greatest impact on our health and well-being can come from our own actions and not so much from the actions of the traditional health-care delivery system. That system is crisis-oriented rather than preventive-oriented.

So I think the only way really —short of having the kind of pure regulatory functions we are talking about here—to do something about what fraction of an individual's income is spent on health care, depends upon how the individual wishes to respond to his own care-taking of his health.

RALPH ANDREANO, PhD

"Basically the physician always is concerned with quality and he always is concerned with the impact of his intervention on his patient, irrespective of cost. To some extent he ought not to compromise on that and that's why we have a high quality system . . . On the other hand, I think physicians will have to become somewhat more acutely conscious of the cost consequences of their actions; and where a low-cost but equal quality intervention is possible, physicians should consider that alternative more and more." (Staff Photos by Ken Opin)

Roerig presents a guide through the labyrinth of vertigo



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Zip_____ Specialty_____

Q. What do you think, if anything, doctors can do either as a group or as an individual to hold down the cost of health care?

A. First of all let me say that since this is an opportunity to talk to all the physicians in Wisconsin, I think we have just a remarkable group of physicians in this state. A number of you have heard me make this statement before but I don't know of any state in the nation where, under the Medicaid Program for example, we have physicians and other providers who are getting paid twice for the same service (quite innocently being paid twice), something on the order of $40,000 a month (or something like that; I have forgottten; it was a very large number: $400,000 in one year). It was returned by the providers, including physicians! I don't know in what other state that could happen; I think the honesty of providers, and especially physicians in this state, is really remarkable and I commend them for that.

"I think the basic equation and what constitutes the pressures for rising health-care costs to the individual citizen are his own perceptions of what he wants out of the health-care system, the insurance system under which we operate, and the extent to which individuals undertake responsibility for their own health."

But to answer your question specifically, I think basically the physician always is concerned with quality and he always is concerned with the impact of his intervention on his patient, irrespective of cost. To some extent he ought not to compromise

Brief Summary

E.E.S.400 FILMTAB®

(ERYTHROMYCIN ETHYLSUCCINATE TABLETS, ABBOTT)

Indications:

Streptococcus pyogenes (Group A beta hemolytic streptococcus)—Upper and lower respiratory tract infections, skin, and soft tissue infections of mild to moderate severity, where oral medication is preferred. Therapy should be continued for 10 days.

Alpha-hemolytic streptococci (viridans group)—Short-term prophylaxis of bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin.

S. aureus—Acute infections of skin and soft tissue of mild to moderate severity. Resistant organisms may emerge during treatment.

S. pneumoniae (D. pneumoniae)—Upper and lower respiratory tract infections of mild to moderate degree.

M. pneumoniae — For respiratory infections due to this organism.

Hemophilus influenzae: For upper respiratory tract infections of mild to moderate severity when used concomitantly with adequate doses of sulfonamides. Not all strains of this organism are susceptible at the erythromycin concentrations ordinarily achieved (see appropriate sulfonamide labeling for prescribing information).

Treponema pallidum—As an alternate treatment in patients allergic to penicillin.

C. diphtheriae and C. minutissimum—As an adjunct to antitoxin. In the treatment of erythrasma.

Entamoeba histolytica—In the treatment of intestinal amebiasis.

L. monocytogenes—Infections due to this organism.

Establish susceptibility of pathogens to erythromycin, particularly when *S. aureus* is isolated.

Contraindications:

Known hypersensitivity to erythromycin.

Warnings:

Safety for use in pregnancy has not been established.

Precautions:

Exercise caution in administering to patients with impaired hepatic function. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. Surgical procedures should be performed when indicated.

Adverse Reactions:

Dose-related abdominal cramping and discomfort. Nausea, vomiting, and diarrhea infrequently occur. Mild allergic reactions such as urticaria and other skin rashes may occur. Serious allergic reactions, including anaphylaxis, have been reported.

7033187

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Rapid, consistent blood levels occur under either fasting or nonfasting conditions.

Allows you to tailor dosage instructions to patient's needs or lifestyle.

Helps combat day-to-day lapses in dosage compliance.

Important for patients who can better remember to take their dosage at mealtime rather than "between meals."

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Please see opposite page for Brief Summary.

on that and that's why we have a high quality system. But what one is hoping for, I think more and more, is that the profession itself will begin to weigh the consequences of physician interventions; so what economists call the cost-quality trade off is more appropriately faced by the physician.

I can appreciate physicians' concerns, however, for malpractice and the like and the whole practice of defensive medicine that goes with it, and I respect those concerns. On the other hand, I think physicians will have to become somewhat more acutely conscious of the cost consequences of their actions; and where a low-cost but equal quality intervention is possible, physicians should consider that alternative more and more.

"In my estimation the physician is the gatekeeper to the health-care system. I think his consciousness level is being raised —perhaps not so willingly—by the state and by other regulatory activities. I am hopeful that physicians, in their role as gatekeepers, will find more and more ways to offer reasonably high quality care to their patients but with some sensitivity as to what these things cost and what impact they have on the total health-care costs in this state."

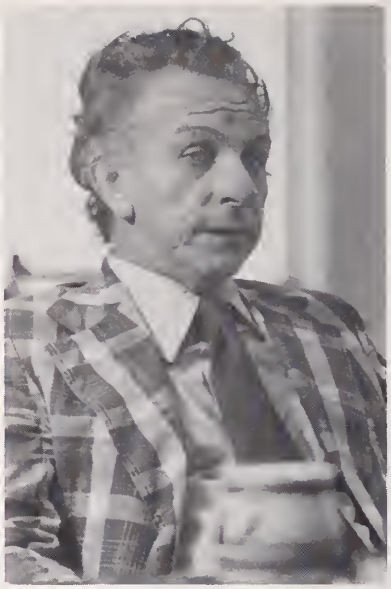
In my estimation the physician is the gatekeeper to the health-care system. I think his consciousness level is being raised, perhaps not so willingly, by the state and by other regulatory activities. I am hopeful that physicians, in their role as gatekeepers, will find more and more ways to offer reasonably high quality care to their patients but with some sensitivity as to what these things cost and what impact they have on the total health-care costs in this state.

Q. You mention regulatory activities. You know as well as I that physicians in this state are very concerned about government and its interference in their practices. They continually say that the traditional physician-patient relationship is being interfered with by the government. For example, the prior authorization mechanism; I think there are a hundred or more items that require prior authorization. Physicians say, "How can someone in government who hasn't seen the patient make a decision about that patient's treatment?"

A. Of course, I can understand what you are saying, but the prior authorizations are done by physician consultants for us. I don't do that. I don't say that a person should have this or that particular thing; the prior authorizations under the Medicaid Program are done for us—in the case of dentistry by trained dental consultants, in the case of surgery by medical consultants.

Q. But, still by the people who haven't seen the patient.

A. Well, that's true, but I think there's certainly a spectrum



"We're going to hire a whole new batch of physician consultants in this state. We are going to regularize these procedures for prior authorization . . . I welcome the input, cooperation, and participation of physicians . . ."

of care for any individual patient on any individual intervention that somebody wishes to make. Within that spectrum there is a broad range of things that are generally accepted as good medical practice. And I think that prior authorization is in some sense trying to standardize what is generally thought of as good medical practice. The present turnaround in the Medicaid Program which we are experiencing now is that we're trying to be somewhat more specific about what criteria—and these are medical criteria—should be applied for prior authorizations.

We are trying to really incorporate what the given state of the art is, in some kind of regular fashion, so that we aren't making capricious or arbitrary decisions. And we have already received, I think, extensive input from the physician community about some of the things we are

attempting to do. And we're going to hire a whole new batch of physician consultants in this state. We are going to regularize these procedures for prior authorization so that we can't fully reduce the area of ambiguity—we can't fully eliminate it—but we want to reduce that area of ambiguity as much as possible.

Q. Do you see government regulation, let's take just physicians, in the health-care field increasing? Is it inevitable, or is there some way in which physicians can hold off increasing government regulation of their profession, or maybe that's not desirable?

A. Well, I guess you're asking for a forecast, and I guess I would forecast yes, increasing regulation for the simple reason that there does seem to be some limit on it because the government has now become one of the major purchasers of health care, of physicians' services and all other health-care services. Government, therefore, becomes concerned about its costs. And because of that I think the government is taking a more interventionist posture and that will spill over into—not so much the way physicians practice or what they do inside their offices or inside their examining rooms—what kind of capital equipment they can have, how they get paid under Medicaid, and things of that kind.

Yes, my forecast would be for increased government regulation both at the federal and state levels and some of that will spill over into and affect physicians. As to whether they can avoid that, speaking specifically to physicians, I rather doubt it. We've really passed that point. When you're talking about investing 9 to 10 percent of your gross national product, you've really passed the point of believing that it's ever going to be less than that.

I think we have reached the threshold of national concern about it, and my guess is that the posture physicians should take is essentially the posture they have been taking in Wisconsin. Given the recent experience, for example, under certificate-of-need in this state, I think it was just remarkable the position the physician community took—in a sense saying okay, if we have to be regulated, let's have an input and let's have some say about how and what way that is done. And I think that is sort of avoiding regulation, but I also think it's a creative response to what's happening and I think physicians should actively become involved in their local planning agencies.

In all aspects, I think what governments' regulatory efforts are, and we certainly want their participation in a more active way than perhaps we have ever had with regard to the Medicaid Program. I have lots of plans for Medicaid if we can ever get rolling.

Q. What are some of those rules or general plans of the Medicaid Program?

A. Well, I am very concerned with the sort of dual nature of the Medicaid Program. On the one hand it's a medical or health program and on the other hand it is a social welfare program. The law is fairly clear. It's a health and medical program, but our benefit structure in this state spans all the way from pure unambiguous medical intervention to reimbursing people who take kids to ball games.

Although, I realize it has to be done slowly, I would like to reemphasize the physician's role as gatekeeper to the health-care system. I'd like to see a lot more of what happens in the Medicaid Program channeled directly through physicians rather than having, as we now have, a whole host of other so-called primary providers such as chiropractors, podiatrists, and the like. I recognize that these groups also have some claim to offering health-care services and I am not saying they don't; but, by and large, if we are really talking about influencing demand for health-care services in this state, we are talking about the physician and

"I have lots of plans for Medicaid if we can ever get rolling . . . I'd like to see a lot more of what happens in the Medicaid Program channeled directly through physicians rather than having, as we now have, a whole host of other so-called providers, such as chiropractors, podiatrists, and the like . . . We intend to put every policy of the Medicaid Program in writing. We intend to have everything in administrative rules. We intend to be above board and open with full disclosure of our payment practices and policies."

I think the Medicaid Program in particular has got to relate more exclusively to physicians' standards, the standards of care that only physicians can order.

So what I am looking forward to, if I live and stay around here long enough, is to shape up the benefits in the Medicaid Program so that they really correspond to health outcomes. We pay for a lot of things as benefits in the Medicaid Program either because the Legislature demands that we do or because some previous bureaucrat thought it was a good idea. We need to more vigorously study what these benefits add up to. Are they improving the health of the Medicaid population? How do we measure improvement? And as we proceed to do that, I think it should indicate to us which benefits we ought to be paying for and which ones we ought not. But it is basically the same approach I would have to the rest of the health-care system; and I think as former Secretary Carballo, others, and myself have been saying, our problems with the Medicaid Program have mirrored the problems we face generally in the rest of the private health-care system.

"One of the crazy ideas I've considered is to have a single entry point for the Medicaid population; that is to say, have an expanded HMP (health maintenance plan) for the Medicaid population. Then we would have physicians really and truly responsible for the care of the Medicaid patient. I understand I can't legally do that, but quite frankly that's the kind of thinking I'm going through."

Q. What do you think of the benefits offered to the Medicaid recipient? Is that going to continue to be a more inclusive package, or do you think . . .?

A. I don't know what more we could offer in this state! I'm thinking the other way around. What can we legitimately give up without affecting the health outcome of the poor population or the Medicaid target population? For example, in the whole area of psychotherapy . . . There's a great deal of scientific controversy over what the merits are, in terms of outcome and the health and mental well-being of the patient. There's a great deal of scientific controversy over what is a legitimate intervention. Legitimate may be psychosocial intervention but is it a legitimate medical intervention. And what I am thinking about is what kind of benefits can we give up that don't materially affect the health of the target population. For example, I see—what we recently have been talking about and I guess what we have actually done —giving up a good fraction of over-the-counter drugs as a benefit. Frankly, given the difficulties with the psychotherapy program, I wouldn't mind giving that up. I said so before the Legislature recently; but if we can get these rules approved, I am willing to try for another year.

At some point the line has to be drawn as to whether this is a welfare program that lets kids and everybody get a piece of the pie or whether it is a health program designed to offer access to health-care services to Medicaid-eligible people who otherwise would not be able to afford or have access to services because they have a health problem.

On the health side one of my greatest concerns with the Medicaid population (and I have discussed this with physicians and with members of the State Medical Society and Milwaukee County Medical Society) is the continuity of care; that is, the way in which we pay and reimburse and the way in which we declare eligibility under Medicaid. I don't believe these methods really insure that poor people have the same kind of continuity of care with a physician and the backup of services that a physician can order. I don't believe that those same things occur for the Medicaid population. If I have a problem with my health, I know my physician is always there. I can always call him. I don't have to worry about standing in a queue for a long time to get a physician or someone to look at me; I know he is there all the time.

"One of my greatest concerns with the Medicaid population . . . is the continuity of care . . . the way in which we pay and reimburse . . . declare eligibility . . ."

One of the crazy ideas I've considered is to have a single entry point for the Medicaid population; that is to say, have an expanded HMP (health maintenance plan) for the Medicaid population. Then we would have physicians really and truly responsible for the care of the Medicaid patient. I understand I can't legally do that, but quite frankly that's the kind of thinking I'm going through.

To be continued in September

Familial aspects of breast cancer

THE FAMILIAL CHARACTER of breast cancer has been recognized for more than a century. In 1866 Paul Broca, a French surgeon, reported the high incidence of cancer in his family in which 10 of 24 women died of breast cancer. Many such family histories have since been reported, and considerable information is now available on the familial aspects of this disease.

Both epidemiological and family studies have shown that relatives of breast cancer patients are at increased risk of developing breast cancer. The work of Anderson and others[1] indicates the possibility of a familial and a nonfamilial type of breast cancer. The familial type is associated with earlier age of onset and increased incidence of bilateral and multicentric breast carcinomas. Increased occurrence of malignancies of other sites as well as second primaries also have been reported among relatives of breast cancer patients. The daughters of breast cancer patients tend to develop the disease 10 years earlier than their mothers, on the average.[2] Incidence of bilaterality is about 3% in breast cancer patients with a negative family history, but 15% (*ie.* over 5-fold increase) in patients with a positive family history.[3]

Financing for breast prostheses can now be obtained by Medicaid recipients by prescription. For further information contact the Wisconsin Department of Health and Social Services or the American Cancer Society.

Mothers, daughters, and sisters of breast cancer patients have 2 to 3-fold increased risk of breast cancer, compared to the general population.[1] This increased risk seems to be as great for paternal as for maternal relatives.[4] The risks are even higher for various subgroups of relatives. For example, the risk increases 3-fold for relatives of premenopausal breast cancer patients and 5.4-fold for relatives of bilateral breast cancer patients. Relatives of patients who had both premenopausal and bilateral cancer have a risk factor of almost 9.[4] Sisters of breast cancer patients whose mothers also had the disease constitute another subgroup with a very high risk of breast cancer.[5]

Certain endocrine abnormalities have been identified in relatives of breast cancer patients. Estradiol-plus-estrone (estrogen fractions) and prolactin levels are increased in daughters of breast cancer patients.[6] Decreased excretion of urinary androgens (androsterone and etiocholanolone) has been associated with breast cancer risk. Bulbrook et al[7] observed lowered excretion of androgen metabolites in sisters of breast cancer patients in the age group of 31-40 years.

Relatives of breast cancer patients are at higher risk for breast cancer and for cancers of other sites as well. Cancer of the breast may be associated with cancers of the colon, stomach, ovary, endometrium, and soft tissue malignancies in other relatives.[8] Li and Fraumeni[9] reported a familial association of sarcoma, leukemia, lymphoma, and breast cancer.

Inheritance of breast cancer appears to be complex. Some families show site-specific inheritance of breast cancer, consistent with an autosomal dominant pattern, while in others inheritance seems to be autosomal recessive. However, the exact inheritance patterns are usually not clear. What is inherited is probably a genetic predisposition to develop malignancies, but the exact type may depend upon the interaction of various environmental factors.

Awareness of these familial aspects of breast cancer is important in clinical practice, as members of these families constitute a population which is at high risk of developing cancer. This population needs more careful surveillance. Certain prophylactic measures have been suggested for some of the subgroups at very high risk. One such procedure is prophylactic bilateral mastectomy with insertion of cosmetic prostheses. Feinleib[10] has shown that oophorectomy before age 40 reduces breast cancer risk to one fourth that of the general population. Further research into identification of risk factors and definition of high risk populations are needed to clarify the indications for such prophylactic measures.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

CANCER COLUMN

PREPARED AND SUPPORTED BY
WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH
STATE MEDICAL SOCIETY OF WISCONSIN
AND ITS
COMMITTEE ON CANCER

REFERENCES

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—GAMINI S SOORIYAARACHCHI, MD

Fall Cancer Conference: October 8, 1977, University of Wisconsin Hospitals. See YELLOW PAGES for details.

Dial Access

For a catalog of the tape recordings of recent diagnostic and therapeutic information on specific neoplastic disease problems which are available to Wisconsin physicians, dentists, nurses, and students, contact the Wisconsin Clinical Cancer Center. ■

Public Information Commission approves project to help MDs at county level

The Commision on Public Information, July 24, approved new projects and reviewed ongoing activities, all geared to help physicians in their relationships with the news media and the public.

The Commission "strongly endorsed" a statement prepared by the Communications Department outlining a program for developing local relationships between physicians and the news media.

The structure statement suggests that each county medical society president appoint a public relations/communications committee from among its county society physicians. The Communications Department, under the direction of Rick Fetherston, will aid the county societies in this media relations task by sending regular and special mailings to the committee members to update them on the positions and issues of organized medicine.

Additionally the Commission asked the Communications Department staff to launch pilot communications programs statewide, similar to the one held in LaCrosse two months ago. The LaCrosse program consisted of a panel discussion where members of the media and physicians talked about the interaction of medicine and media professions.

The Commission also approved a proposal to start a newspaper advertising campaign to tell the physician viewpoint on rising healthcare costs. County society presidents will receive sample advertisements, prepared by the Communications Department, with the option of placing the advertisements in their local weekly or daily newspapers. If the county society elects to place the advertisement, the SMS will send a reproduction proof, or mat, of the advertisement ready for newspaper publication.

The Commission feels this will be an excellent method for presenting the physician's message to the public and in building better relationships with the news media.

The Commission also discussed several continuing Communications Department projects.

The "Communications Guide for Wisconsin Hospitals and Physicians" has been distributed to the state media. It also was printed in the June BLUE BOOK issue of the *Wisconsin Medical Journal.*

This guide, which was prepared to promote cooperation between the allied medical professions and the news media, already has received favorable comments from news media personnel around the state.

Commission members were enthusiastic about the success of the "health-cost brochure," which the Communications Department recently prepared in response to physician requests. So far, more than 100,000 brochures have been distributed statewide. Physicians who want additional copies of the brochure may order them from the SMS Communications Department in Madison.

Earlier this year SMS and a Madison advertising firm prepared a series of five public service radio announcements on preventive medicine. Early data indicate that most of the state's 186 radio stations have been airing the announcements regularly.

Herbert F Sandmire, MD, Green Bay, was elected chairman of the Commission; and Charles Sorensen, MD, Wisconsin Rapids, was elected vice-chairman. ■

SMS Variable Annuity

. . . Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.38 as of June 30, 1977. ■

Physicians, contact your legislators!

Physicians are urged to contact their respective state senators and representatives in support of several professional liability bills currently before the Legislature. It's vitally important that legislators know the physician's viewpoint on these issues.

AB 705—would make minors susceptible to the adult statute of limitations in professional liability claims, which is three years from the occurrence of the alleged malpractice. Currently the statute for minors is 18 years of age plus one year, resulting in a 19-year "tail" for minors. Every major study of professional liability has indicated that this "tail" significantly contributes to the high cost of professional liability insurance for physicians.

AB 705—also contains an exception for very young children. Under the new statute, claims would have to be filed by age eight, or within three years, whichever is later. Statistics gathered by the National Association of Insurance Commissioners show that there is no need for a long tail, since 96 percent of all reportable incidents are filed by age eight.

AB 716—allows for a preservice voluntary binding arbitration agreement between physicians and their patients. While such agreements are permitted under the professional liability law in Wisconsin, AB 716 would specifically provide for the agreements and clarify the procedures to be used. Agreements such as these are acceptable under the general Wisconsin "contract law."

Thus, AB 716 is primarily a "housekeeping bill" designed to clarify minor inconsistencies between the existing arbitration law and Chapter 655 (professional liability).

AB 717—attempts to deal with the general problems of double payment of benefits to successful plaintiffs in malpractice actions. It provides that benefits already received by a successful plaintiff in a professional liability action from sources independent of the defendant; *ie*, Social Security, Worker's Compensation, and private health insurance benefits will be deducted from the award granted by a panel court or arbitration panel. This award comes from the physician-supported Wisconsin Patients Compensation Fund. ■

NHI committee holds Wisconsin hearings in August

The US Department of Health, Education and Welfare's Advisory Committee on National Health Insurance (NHI) held hearings this month in Marshfield and Madison to discuss various aspects of NHI. The hearings are part of a national effort to provide committee members with various viewpoints as the committee prepares to make its legislative recommendations to President Carter.

Speakers at the conferences agreed that any national health insurance plan adopted by Congress would retain fee-for-service as the primary reimbursement plan for health services and that it would be a pluralistic program.

Uwe Reinhardt, a noted health economist from Princeton University, told committee members, "I cannot imagine that the United States will depart from fee-for-service as the basic reimbursement mechanism under any health insurance plan adopted by this country."

"A fee schedule will have to be negotiated," Reinhardt said. "This will have to be agreed upon ahead of time. Every country which has NHI has had a negotiated fee schedule. It must be negotiated with the medical community, and not be imposed by a group of professors and civil servants."

The Princeton economist added that there should be a ceiling on the total amount of dollars paid to physicians under any NHI plan adopted by the United States.

Reinhardt maintained there "should be only one fee for a service, regardless of who does it. If a procedure can be performed by a physician extender as well as by a physician, the cost of that procedure should be at the level charged by the extender."

SMS President Roy B Larsen, MD said he, too, was "appalled by the variances in fees for the same procedures around the country."

Doctor Larsen said that the Independent Practice Association (IPA) has proved to be an effective method of cost control for medical fees. He described it as a cooperative effort by hospitals, physicians, and insurance companies which preserves fee-for-service and free choice of physician.

In the IPA fee schedules are submitted for a one-year period, and no deviations during the period of agreement are allowed. The Board of Directors, or the Operating Committee, then examines unusual changes of hikes in fees and makes adjustments when necessary.

"The first prototype plan has been in operation now for over five years and during that period, member physicians have been at 100 percent risk," Dr Larson said. "We have seen effective cost control and decrease in hospitalization during this period."

The main topic at the Madison hearing centered on how health planning should be integrated into any NHI system.

James Kimmey, MD, director of the Midwest Center for Health Planning, maintained that Health Systems Agencies (HSAs) could assist NHI in devising the NHI plan, in monitoring and identifying problem areas, in obtaining community reaction to regulation, and in evaluating the impact of the cost containment mission of NHI.

Doctor Kimmey went on to make several recommendations regarding NHI. He said any NHI plan must: (1) separate the support of resource development (manpower, facilities, etc), from patient-care services; (2) develop incentives or disincentives to reward providers who best serve the community's needs; (3) provide for capital expenditure controls tied to rate reimbursement and link those to the planning process; (4) promote alternative delivery mechanisms through incentives in the funding mechanism, and (5) assure open access to the data generated by PSROs, but with protection of patient rights.

Jacob Getson, assistant commissioner of the Massachusetts Department of Public Health and executive director of the Office of State Health Planning, talked about the problems of health care in his state.

He said Massachusetts has had difficulty in controlling expenditures in its public programs and the state is now intervening in every level of decision-making in the hospitals, nursing homes, and physician services. He stressed the need for a single financing mechanism in NHI, but added, "We can't walk away from issues of quality and access as serious as the cost problem is."

Any NHI program must include a preventive medicine program of some type, Getson said, as a means of attempting to make some changes in the health care of people. He mentioned pollution control and changes in life-styles as examples of this.

A member of the AMA Council on Legislation, Edgar T Beddingfield, MD, then questioned whether government should have the authority to decide where doctors should practice, what services they should provide, and what supplies and equipment they can use.

Getson replied that the planners "do not want to control what the doctors do or where they practice, but rather, how many total dollars may be spent for health care."

Doctor Kimmey responded that the health-care planners are actually driving for community-based planning rather than Washington, DC control of a local situation. ■

House of Delegates Nominating Committee to meet

The House of Delegates Nominating Committee will hold a meeting Sunday, September 25, at 10.00 AM at the SMS headquarters in Madison.

County medical societies are urged to nominate members for the offices of president-elect and vice-speaker for 1978-79 and AMA delegates for calendar years 1979-1980.

Currently Jules D Levin, MD, Milwaukee, is president-elect; Duane W Taebel, MD, LaCrosse, is vice-speaker.

AMA delegates whose terms expire at the end of 1978 are: MDs John E Dettmann, Green Bay; George E Collentine, Jr, Milwaukee; and DeLore Williams, West Allis.

AMA alternate delegates with similar terms ending are: George A Behnke, Kaukauna; Harold J Kief, Fond du Lac; and Patricia J Stuff, Bonduel.

Nomination information should be sent to the Nominating Committee in care of the SMS office in Madison as soon as possible. All candidates are encouraged to present themselves at the September meeting. ■

CME Commission, WisPRO meet

The Commission on Continuing Medical Education in July met with representatives of the WisPRO (Wisconsin Professional Review Organization) Continuing Education Committee to discuss the interrelationship of these two committees.

The CME Commission expressed a firm interest in assisting WisPRO in implementing the CME programs that are directed at the areas of need identified by the data from WisPRO.

The CME Commission strongly felt that the utilization of WisPRO data could provide an invaluable tool in directing programming toward specific concerns. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of June 10, 1977

NEW MEMBERS

Key: (Date of birth, membership classification, specialty/sub-specialty)

County Medical Society

DANE

Caceres, Victor W, 38 S Brooks St, Madison 53715 (1949, Resident, Pathology)

Chandra, Suresh R, 1300 University Ave, Madison 53706 (1937, Regular, Ophthalmology, Certified)

Harrington, John Jr, 1313 Fish Hatchery Rd, Madison 53715 (1940, Regular, Internal Medicine/Rheumatology, Certified-IM)

Schammel, Francis M, 109 Forest St, Stoughton 53589 (1926, Regular, General Practice)

Totel, Gregory L, 4239 Morris Park Rd, McFarland 53558 (1945, Resident, Internal Medicine)

Welnick, Richard O, 20 S Park St, Madison 53711 (1947, Regular, Internal Medicine, Certified)

DOUGLAS

Franco, Jon F, 3600 Tower Ave, Superior 54880 (1944, Regular, Pediatrics, Certified)

LACROSSE

Annis, Byron L, 1836 South Ave, LaCrosse 54601 (1937, Regular, Neurological Surgery)

MANITOWOC

Kadile, Eleazar M, 600 York St, Manitowoc 54220 (1939, Regular, Psychiatry/Neurology)

Kadile, Hermengildo, 600 York St, Manitowoc 54220 (1930, Regular, Psychiatry/Neurology)

MILWAUKEE

McGrath, David J, 2400 S 90th St, Suite 112, West Allis 53227 (1928, Regular, General Surgery/Thoracic Surgery, Certified-GS)

OZAUKEE

Mammen, Aykarethu O, Grafton Medical Center, Grafton 53024 (1941, Regular, General Surgery/Cardiovascular Surgery, Certified-GS)

PORTAGE

Jarabek, Joseph F, 2501 Main St, Stevens Point 54481 (1945, Regular, Internal Medicine, Certified)

WOOD

Banerjee, Timir, 1000 N Oak Ave, Marshfield 54449 (1943, Regular, Neurological Surgery, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

BARRON-WASHBURN-BURNETT

Cornforth, Donald E, Rice Lake, to 244 Elwood Beach Rd, Shell Lake 54871

DANE

Douglas, Donald D, Middleton, to 708 Highland Terr, Williamsport, PA 17701

MARINETTE-FLORENCE

Rogers, Raymond J, North Palm Beach, FL, to 111 Shore Court, Rte 1, Box 49, Oconto 54153

MILWAUKEE

Hettwer, Rose A Kriz, Sudbury, MA, to 2527 Menlo Blvd, Shorewood 53211

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Family Physicians

. . . elected the following officers at the Annual Meeting of the Wisconsin Academy of Family Physicians last month in Fontana.

James N Moore, MD* of Madison was elected president-elect. He will take office next July, succeeding Richard K Chambers, MD* of Hartland who was installed as president at this year's meeting.

John O Grade, MD* of Elm Grove was elected secretary-treasurer. Robert F Purtell Jr, MD,* Milwaukee, was named speaker of the Congress of Delegates; and Henry C Rahr, MD,* Green Bay, was named vice-speaker.

New members of the Board of Directors include MDs Theodore C Fox,* Antigo; Norman C Schroeder, Manitowoc; Charles L Steidinger,* Platteville; James L Esswein, Chetek. Doctor Fox was elected chairman of the Board.

The Academy, formed in 1948, has 975 members who are family physicians in Wisconsin. The Wisconsin Chapter is the 11th largest state chapter of the American Academy of Family Physicians.

AMA Annual Convention

. . . faculty members from Wisconsin who participated in postgraduate sessions at the AMA annual convention held in San Francisco in June are: MDs Judith Donegan,* Milwaukee—*Advanced Life Support-Cardiopulmonary Resuscitation (CPR)*; John L Melvin,* Milwaukee—*Clinical Electromyography for the Referring Physician;* Charles Altshuler, Milwaukee—*Toward More Appropriate Utilization of Laboratory Tests: Maximizing Clinical Information From Laboratory Tests;* Frederick S Brightbill,* Madison—*Endothelial Cell Loss During Penetrating Keratoplasty;* and Calvin Kunin, Madison—*Hospital-Acquired Urinary Tract Infections.*

Wisconsin Physicians

. . . recently had scientific exhibits at the 126th annual AMA convention which was held in June in San Francisco. They are MDs Stephen B Webster,* LaCrosse—*Asymptomatic Gonorrhea in Clinical Dermatology;* Sue Hausserman, Robert Hausserman, Joseph Sackett,* Alan Breed and Henry Okagaki,* Madison—*Spinal Anomalies Studied with Metrizamide, A New Water Soluble Contrast Medium;* R H Matallana, Madison—*Negative Modality in Xeromammography;* Andrew B Crummy,* Ronald S Rankin, William D Turnipseed, and Herbert A Berkoff, Madison—*Biplane Arteriography in Lower Extremity Ischemia;* and William J Zwiebel, Madison—*Renal Osteodystrophy: Pathophysiologic, Radiologic Correlation.*

Heritage Bank-Mayfair

. . . has awarded three Heritage student research fellowships to the Medical College of Wisconsin. The fellowships will provide $800 each for three medical students to do research during a two-month period under the director of a faculty member.

Because of the importance of summer research grants, the college has allocated $4,000 for providing fellowships to an additional five students. The eight students selected this summer are: Stephen Becker; Cynthia Bergmann; Thomas Halloin; Howard Mahler; Lawrence McKean and Brian Vlcek of Milwaukee; and Susan Keay, Wauwatosa and Carol Popp-Hanlon, Kenosha.

Grants to the Medical College

. . . of Wisconsin increased almost a million dollars for the year ending June 30, 1977. Total research, training and teaching grants totaled $9,063,450 for the past years compared with $8,168,409 for the 1975-76 fiscal year. This is the highest amount ever received by the college.

The largest amount, approximately 80 percent, comes from federal sources. Grants for research, training and scholarships were also received from health agencies, foundations, corporations and individuals.

Columbus Community Hospital

. . . a new 68-bed facility to be built in the Parkview addition of Columbus, had its groundbreaking ceremony in mid-June. Construction on the $3.8 million multi-story building was to start immediately with completion set for November 1978.

PHYSICIAN BRIEFS

James Damos, MD
Robert Mortimore, MD
Michael Schonfeld, MD

. . . recently opened their office in Reedsburg in family practice. The doctors completed their residency training at Edward Sparrow Hospital, Lansing, Mich. Doctor Damos graduated from St Louis University School of Medicine; Doctor Mortimore graduated from Northwestern Medical School in Chicago; and Doctor Schonfeld graduated from Wayne State University Medical School in Detroit.

Alexandre L Slatkin, MD

. . . recently began his practice in internal medicine in Sheboygan. Doctor Slatkin is associated with MDs Thomas Mockert Jr* and William A Forkner.* A graduate of the University of Rio de Janeiro, he has completed a fellowship in pulmonary disease at University of Louisville affiliated hospitals. He also served his internship at Maimonides Medical Center, Brooklyn, and his residency at University of Cincinnati hospitals.

Donald E Casebolt, MD

. . . recently joined the medical staff at River Pines Community Health Center, Janesville, as medical director. He is a graduate from Loma Linda University School of Medicine in California, and completed an internship at San Diego Naval Hospital. Prior to coming to River Pines, he was engaged in family practice in Brewster, Wash.

Jeffrey R M Kunz, MD

. . . a 1977 graduate of the University of Wisconsin Medical School, Madison, and former editor of the medical school newspaper, has been named the first fellow in the American Medical Association's new Dr Morris Fishbein Fellowship in Medical Journalism Program. The fellowship program provides a ten-month training period in medical journalism by working all aspects of the professional publishing programs of the American Medical Association. Doctor Kunz, who also studied at London University and Glasgow University, Scotland, plans a career in medical journalism.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Michael McFadden, MD
. . . has become associated with the medical staff of the Door County Medical Center, Sturgeon Bay. Doctor McFadden graduated from the University of Utah Medical School and served his internship at U S Tripler General Hospital in Honolulu, Hawaii. He completed his residency in urology at St Louis University affiliated hospitals.

Gregory G Smith, MD
. . . native of Manitowoc, recently joined the medical staff of the Riverview Clinic, Janesville, in the practice of pediatrics. Doctor Smith received his medical degree from the University of Wisconsin Medical School, Madison, served his residency training at the University of Virginia and also studied under an Ambulatory Pediatrics Fellowship at the University of Wisconsin in Madison.

Santiago Yllas, MD
. . . Racine, recently opened his office in family practice. A 1967 graduate from medical school, Madrid, Spain, he served a surgery internship at Cedars of Labanon Hospital, Miami; pathology residency at the University of Tennessee, Memphis; family practice residency at Louisville Memorial Hospital, Kentucky, and did family practice work in Hopkinsville, Ky. Prior to opening his office in Racine, Doctor Yllas had been at Chicago's Cook County Graduate School of Medicine where he took an education course in family practice.

Pablo Perez, MD
. . . Racine, recently opened his office in Plymouth. A native of the Philippines, Doctor Perez graduated from Manila Central University Medical School and served a rotating internship at the Illinois Masonic Medical Center, Chicago. He was an emergency room physician at St Luke's Hospital, Racine, and at Kenosha Memorial Hospital prior to moving to Plymouth.

Richard A Henry, MD
. . . Chippewa Falls, recently joined the medical staff of St Joseph's Hospital in the Department of Pathology. Doctor Henry is a graduate of the University of Wisconsin Medical School, Madison, where he also served his internship and residency.

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ON THE SQUARE *IN MADISON*

Donald R Griffith, MD*
. . . of the Midelfort Clinic in Eau Claire is the program chairman for the American Group Practice Association's Annual Meeting in Houston, Texas, October 5-8. More than 15,000 ambulatory care physicians in over 425 medical groups are expected to participate in this program which has been designed to help ambulatory care physicians solve current problems.

Small group workshops—a traditional feature at AGPA Annual Meetings—will take on a not-so-traditional appearance as participants look into such areas as sabbaticals, handling the problem doctor, primary care in a multispecialty clinic, problems of the management team, labor relations and long-range planning. In addition, major governmental officials and elected representatives have been invited to share their viewpoints with the nation's group practice physicians.

Roy C Blank, MD
. . . Manitowoc, recently became associated with the Manitowoc Clinic in the Department of Internal Medicine. He graduated from the University of Maryland Medical School and completed his internship and residency at University of Minnesota Hospitals. Prior to joining the medical staff of the Manitowoc Clinic, Doctor Blank had served as a major in the United States Army Medical Corps at Ft McClellan, Ala.

Thomas S Westcott, MD
. . . Pardeeville, is the newly elected president of the medical staff of Divine Savior Hospital in Portage. Other MDs elected to office are: Stewart F Taylor,* Portage, vice-president; Celso A Villavicencio,* Portage, secretary-treasurer; and Jack J Saxe* of Portage, past president, also will serve on the executive committee.

Manuel C de Leon, MD
. . . Sheboygan, recently assumed the medical practice of Joseph F Kovacic, MD,* who retired. Doctor de Leon is a graduate of the University of Santo Tomas Medical School, Manila, The Philippines, and completed his residency in internal medicine at Wayne State University affiliated hospitals in Detroit.

Charles J Siegel, MD
. . . Middleton, recently became associated with the medical staff of the Quisling Clinic, Middleton. Doctor Siegel graduated from the Medical College of Wisconsin, Milwaukee, and completed his internship and residency training at Children's Mercy Hospital, Kansas City, Mo.

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John F Pederson, MD*
James K Wiesener, MD
. . . recently became associated with the medical staff of Howard Young Medical Center, Woodruff, and Lakeland Medical Associates Ltd, respectively. Doctor Pederson, a pathologist, graduated from the University of Wisconsin Medical School, Madison, served his internship at University of Minnesota Hospitals, Minneapolis, and completed his residency at University Hospitals in Madison. Doctor Wiesener, a specialist in internal medicine, graduated from the University of Wisconsin Medical School, Madison, and completed his internship at University Hospitals in Madison. His residency also was completed at University Hospitals in Madison.

Horace J Hansen, MD*
. . . family physician in Sheboygan Falls for 43 years, will officially retire at the end of 1977 because of ill health. A 1934 graduate from the University of Wisconsin Medical School, Madison, Doctor Hansen served his internship at Milwaukee County General Hospital. In World War II, Doctor Hansen served as a Lt Cmdr in the South Pacific for the United States Navy.

Frederick J Hofmeister, MD*
. . . Elm Grove, recently received a Vocational Service Award from the Rotary Club of Milwaukee. Doctor Hofmeister has served as president of the American College of Obstetricians and Gynecologists; Wisconsin Society of Obstetrics and Gynecology; Milwaukee Gynecological Society, and the Central Association of Obstetricians and Gynecologists. The American Medical Association presented him with the Physician's Recognition Award three times and in 1965 the State Medical Society of Wisconsin gave him the Council Award for 15 years of service to the Society. He is on the medical staff of five hospitals in the Milwaukee area and is clinical professor of gynecology and obstetrics at the Medical College of Wisconsin. Earlier this year, he received an honorary doctorate in science from Hanyang University in Seoul, Korea.

Jan P DeRoos, MD
. . . an orthopedic surgeon, recently became associated with the medical staff of the Sheboygan Clinic. A graduate from the University of South Dakota School of Medicine and the University of Chicago Pritzker School of Medicine, Doctor DeRoos served his internship and residency training at the Mayo Clinic, Rochester.

Stephen Westcott, MD
. . . an internist, has joined the medical staff of the Sheboygan Clinic. Doctor Westcott graduated from the University of Wisconsin Medical School, Madison, and his internship and residency were combined at the University of Utah Affiliated Hospitals, Salt Lake City.

Ronny W Wenang, MD
. . . recently became associated with the medical staff of Parkview Medical Associates, Ltd. A specialist in obstetrics and gynecology, Doctor Wenang graduated from the Pajajaran State University Medical School, Bandung, Indonesia. He completed a rotating internship at Mercer Medical Center, Trenton, NJ, and his residency was taken at Presbyterian Hospital, University of Pennsylvania Medical Center. Doctor Wenang is a Junior Fellow of the American College of Obstetricians and Gynecologists.

James A Burns, MD
. . . recently became associated with the Indianhead Clinic in Rice Lake. Doctor Burns is originally from New York City and graduated from Cornell University Medical School. He completed his residency training in surgery at the University of Iowa. Doctor Burns served in the United States Air Force in Oklahoma and later became a mission doctor in Africa.

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Jerome H Hagens, MD

. . . Appleton, recently became associated with James E Gmeiner, MD,* in the practice of orthopedic surgery. He received his medical degree from Marquette University School of Medicine in 1967 and interned at Swedish Hospital, Seattle, Wash. Doctor Hagens served in the United States Army for two years and was on the medical staff of Michael Reese Medical Center, Chicago. Prior to moving to Appleton, he was in private practice in Ashland, Ore.

Badri N Ganju, MD

. . . Chilton, recently was added to the medical staff of Calumet Memorial Hospital. A general surgeon, Doctor Ganju received his degree from the Medical College, Nagpur, India. His residency was taken at the University of Illinois in the metropolitan group hospitals program. Prior to accepting the position in Chilton, Doctor Ganju served for a year in emergency room surgery at McHenry Hospital in Illinois.

William Kelly, MD

. . . Park Falls, recently joined the medical staff of the Birch Street Clinic. He completed his internship at the United States Public Health Service Hospital, Baltimore, Md. He is a 1976 graduate from the Medical College of Pennsylvania.

Frederick A Klemm, MD
Joseph M Monaco, MD
Phillip M Zickerman, MD

. . . Wausau, have joined the medical staff of the Wausau Medical Center. Doctor Klemm is in emergency services; Doctor Monaco in pediatrics and Doctor Zickerman will practice urology. Doctor Klemm is a graduate from the University of Illinois Medical School and served his internship at LaCrosse Lutheran Hospital and Gundersen Clinic. His residency training in emergency medicine was completed at Carle Clinic and Hospital, Urbana, Ill, and the Burnham City Hospital in Champaign, Ill. Doctor Monaco graduated from the University of Vermont College of Medicine and completed his internship and residency training in pediatrics at Albert B Chandler Hospital of the University of Kentucky in Lexington. Doctor Zickerman graduated from the State University of New York Downstate Medical College, Brooklyn, NY. He served his internship and residency training in urology at the University of Vermont Hospitals, Burlington, Vt.

Thomas O Orvald, MD

. . . formerly of Burbank, Calif, recently began his medical practice in cardiovascular and thoracic surgery in Wausau. A graduate from the Hahnemann Medical School, Philadelphia, Pa, Doctor Orvald has had 15 years of medical experience including several teaching appointments. He is board certified from the American Board of Surgery and the American Board of Thoracic Surgery. He is associated with A Ward Ford Memorial Institute and Wausau Hospitals.

Dominic J Martinetti, MD*

. . . Hurley family practitioner since 1940, recently was honored in a "Dr Martinetti Appreciation Day." He graduated from the University of St Louis Medical School in 1938 and served his internship at St Mary Group hospitals in St Louis, Mo. His residency was taken at St Joseph's Hospital, St Charles, Mo. Doctor Martinetti served as a volunteer physician in South Vietnam and is a past president of the Iron County Comprehensive Health Committee.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JULY 1977

6 Title 19 Provider Agreement
12 Dane County Medical Society Board of Trustees
13 SMS Committee on Federal Legislation
13 SMS Commission on Governmental Affairs
18 WisPRO-FMCE Long Term Care Committee
20 SMS Commission on Peer Review
21 SMS Commission on Public Information
21 WHCRI Board of Directors
22 WHCRI Long Term Care Committee
28 SMS Committee on Aging and Extended Care Facilities
29 SMS Commission on Continuing Medical Education

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

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Luis D Borella, MD
. . . professor of pediatrics at the Medical College of Wisconsin, and director of Immunology Research at Milwaukee Children's Hospital, recently was awarded a research grant from the American Cancer Society. Doctor Borella's research program is entitled "The Distribution and Functions of Lymphoid Cell Subpopulations in Acute Leukemia."

Donald Levy, MD*
. . . Milwaukee, is the newly elected president of the Wisconsin Society of Plastic Surgeons. Doctor Levy graduated from Louisiana State University Medical School, New Orleans, and served his residency at the Mayo Clinic in Rochester, Minn. He is chief of plastic surgery at Columbia Hospital, Milwaukee.

David P Losh, MD
. . . Davenport, Iowa, announced he will set up his medical practice in October in Oconto. A specialist in family practice, Doctor Losh is finishing his family practice residency in Davenport.

Edward P Blau, MD
. . . a pediatric nephrologist, recently became associated with the Marshfield Clinic. A graduate from St Louis University Medical School, he served his internship and residency at the University of Minnesota. Prior to moving to Marshfield, Doctor Blau had practiced at Children's Hospital in Pittsburgh, Pa.

Anthony Pisciotta, MD*
. . . Elm Grove, recently was honored as the "1977 Alumnus of the Year" by the Marquette-Medical College of Wisconsin Medical Alumni Association. A professor of medicine at the Medical College of Wisconsin and director of the Blood Research Laboratory at Milwaukee County General Hospital, he was cited for his many achievements in the field of hematology. The award was presented by Robert F Purtell, Jr, MD,* Brookfield, alumni president.

Frederick W Knoch, III, MD
. . . has joined the medical staff of the Community Emergency Services, Inc at St Elizabeth Hospital in Appleton. Doctor Knoch graduated from Loyola University Medical School, Chicago, and served his internship at Loyola University Hospital. He served in the United States Army from 1972-74 and served his residency at St Francis Hospital, Peoria, Ill. He also was director of the residency program at St Francis Hospital when he accepted the position in Appleton.

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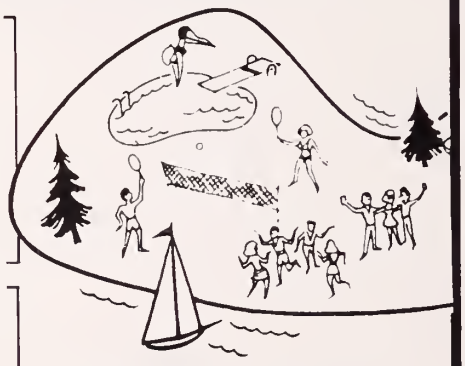

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AMA Judicial Council Statement on Advertising and Solicitation

THIS STATEMENT reaffirms the long-standing policy of the Judicial Council on advertising and solicitation by physicians. The Principles of Medical Ethics are intended to discourage abusive practices that exploit patients and the public and interfere with freedom in making an informed choice of physicians and free competition among physicians.

Advertising.—The Principles do not proscribe advertising; they proscribe the solicitation of patients. Advertising means the action of making information or intention known to the public. The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and other useful information that will enable people to make a more informed choice of physician.

The physician may furnish this information through the accepted local media for advertising or communication, which are open to all physicians on like conditions. Office signs, professional cards, dignified announcements, telephone directory listings, and reputable directories are examples of acceptable media for making information available to the public.

A physician may give biographical and other relevant data for listing in a reputable directory. A directory is not reputable if its contents are false, misleading, or deceptive or if it is promoted through fraud or misrepresentation. If the physician, at his option, chooses to supply fee information, the published data may include his charge for a standard office visit or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting the amount of the fee specified. The published data may include other relevant facts about the physician, but false, misleading, or deceptive statements or claims should be avoided.

Local, state, or specialty medical associations, as autonomous organizations, may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the Principles of Medical Ethics. Furthermore, specific legal restrictions on advertising or solicitation of patients exist in the medical licensure laws of at least 34 states. Other states provide regulation through statutory authority to impose penalties for unprofessional conduct.

Solicitation.—The term "solicitation" in the Principles means the attempt to obtain patients by persuasion or influence, using statements or claims that (1) contain testimonials, (2) are intended or likely to create inflated or unjustified expectations of favorable results, (3) are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice, or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived.

Competition.—Some competitive practices accepted in ordinary commercial and industrial enterprises—where profit-making is the primary objective—are inappropriate among physicians. Commercial enterprises, for example, are free to solicit business by paying commissions. They have no duty to lower prices to the poor. Commercial enterprises are generally free to engage in advertising "puffery," to be boldly self-laudatory in making claims of superiority, and to emphasize favorable features without disclosing unfavorable information.

Physicians, by contrast, have an ethical duty to subordinate financial reward to social responsibility. A physician should not engage in practices for pecuniary gain that interfere with his medical judgment and skill or cause a deterioration of the quality of medical care. Ability to pay should be considered in reducing fees, and excessive fees are unethical.

Physicians should not pay commissions or rebates or give kickbacks for the referral of patients. Likewise, they should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public.

Freedom of choice of physician and free competition among physicians are prerequisites of optimal medical care. The Principles of Medical Ethics are intended to curtail abusive practices that impinge on these freedoms and exploit patients and the public. ■

PHYSICIANS: PRACTICES AND positions. We are specialists in the medical staffing field and provide a unique service to physicians seeking a meaningful affiliation as well as medical organizations desiring to enhance their expanding staffs. Due to our unlimited national exposure to qualified physicians and organizations, we are able to identify, isolate and select only those medical professionals who best satisfy your individual requirements. Our service eliminates unnecessary involvement and misdirected time and energy, leaving you the ultimate task of choosing the most desirable affiliation or candidate from those currently available. Our consultants are dedicated to locating that particular practice or ideal medical associate in order to increase your health-care capabilities through mutual compatability and harmony. Relocation and placement expenses are assumed by client organization or group. For personal service regardless of medical specialty forward position specifications, resumé or vitae in confidence to: John Rafferty, Medical Staffing Administrator, H S Placement Service, Inc, PO Box 3247, Green Bay, WI 54303. Tel: 414/494-9586. 8-9/77

MEDICAL FACILITIES

KENOSHA: NEW PROFESSIONAL office suite. Layout awaiting tenant's requirement. 1000 sq ft. Phone 414/654-4070. 5906 39th Avenue. 7-8/77

AVAILABLE FOR MULTIPURpose uses; *eg*, outpatient, ambulatory care, clinic, group practice. Former hospital building at 1971 W Capitol Dr, Milwaukee. Two-story brick, air-conditioned, sprinklered. Tel: 312/746-1971. p8-9/77

RETIRED GENERAL SURGEON'S professional equipment for sale. Can be purchased in entirety or separately. Call 608/846-5661 between 8:30-10 PM. 8/77*

OFFICE FACILITIES WITH COMplete laboratory and x-ray for general practitioner, internist or OB-GYN located in medical arts building, southwest suburb of city of Green Bay, Wis. Easy access to three hospitals. G E LeMieux, MD, PO Box W-200, De Pere, Wis 54115. 6-8/77

MEDICAL OFFICE FURNITURE: Examining table, upright cabinet, equipment table, desk with chair and 6 wooden arm chairs—used in waiting room. Will contribute to anyone who will pay the cost of moving them. Contact Mrs John M Albino, 438 Shoreland Dr, Racine, Wis 53401. g8tfn/77

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

WANTED TO BUY: EXAMINAtion room table, horizontal file, cabinets, office furniture, etc. Contact: E G Arellano, MD, tel: 414/324-5043 or 414/324-5581. 5tfn/77

OFFICE SPACE FOR RENT: Courtland Medical Center Building. Excellent location - 68th at West Capitol Drive, Milwaukee, Wis. Full lab and x-ray facilities available. Call 414/463-3704. 3/77*

FOR SALE: MEDICAL BUILDING. Presently leased to two dentists and two MDs. 33-car parking lot, air-conditioned, Northeast Madison. Beautifully maintained, priced to sell. Joha Realty Co. Tel: 608/241-2083 8-9/77*

FOR LEASE: OFFICE SPACE. Professional building, 2888.5 sq ft. Reception room, air-conditioned, 33-car parking lot, can accommodate 2 to 3 MDs, Northeast side of Madison. Joha Realty Co. Tel: 608/241-2083. 8-9/77*

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1975 through Aug 31, 1976 appeared in JAMA (Supplement) Aug 9, 1976.

1977 WISCONSIN

Sep 10-11: *Academic Anesthesia: Fifty Years After* Conference, University of Wisconsin, Madison. Objectives: The appointment of Ralph M Waters, MD to the faculty of the University of Wisconsin in 1927 marked the beginning of a new era in anesthesiology. All sessions at Wisconsin Center. Conference fee: $27 for members of Wisconsin Society of Anesthesiology, $62 nonmembers. Info: CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

Sep 14-15: *Mental Health of the Elderly: An Interdisciplinary Educational Session* at Sheraton Inn, Madison. Info: Health Sciences, UWEX, 610 Langdon St, Madison, Wis 53706. (See further details in box elsewhere in this section.)

Sep 16-17: Dr Robert Shaffer, sponsored by Dept of Ophthalmology, University Hospitals, Madison.

Sep 16-17: Wisconsin Regional Meeting, American College of Physicians, Hotel Hilton, Eau Claire. Info: George E Magnin, MD, 1000 N Oak Ave, Marshfield, Wis 54449.

Sep 21: *Green Bay One-day Seminar for Family Physicians*, at St Vincent Hospital. Further details later.

Sep 24: Wisconsin Dermatological Society. Info: Sharon Lantis, MD, 1552 University Ave, Madison, Wis 53706.

Sep 24-25: Wisconsin Allergy Society. Holiday Inn, Stevens Point. Guest speaker, Dr Elliot Middleton, Buffalo, New York. Accredited for four hours by AMA for Category 1. Info: R L Hansen, MD, 1000 N Oak Ave, Marshfield, Wis 54449.

Sep 30-Oct 2: Wisconsin Neurosurgical Society meeting, at St Vincent's and Bellin Memorial hospitals, Green Bay. Headquarters: Ramada Inn.

Oct 6-7: First meeting of Wisconsin Chapter of American College of Emergency Physicians, at Marc Plaza Hotel, Milwaukee. CME credit will be given. Further details will appear in the August issue.

Oct 7-8: *Geriatric Seminar: What's New for the Old.* Sponsored by Dept of Family Practice, Medical College of Wisconsin, and American Geriatrics Society. Mequon Care Center, Mequon (near Milwaukee). See details elsewhere in this issue.

Oct 7-9: Wisconsin Radiological Society, Concourse Hotel, Madison.

1977 WISCONSIN

Oct 8: *Fall Cancer Conference,* sponsored by Wisconsin Clinical Cancer Center/American Cancer Society/UW-Extension, CME Department; at University of Wisconsin Hospitals, Madison. See details elsewhere in this section.

Oct 19: *Green Bay One-day Seminar for Family Physicians,* at Bellin Memorial Hospital. Further details later.

Nov 12: *Current Advances in Diagnosis and Treatment.* St Joseph's Hospital Clinic Day, Milwaukee, Wis. Guest speakers, Drs Jay Sanford and Jack McGiff. Info: Thomas P Driscoll, MD, St Joseph's Hospital, 5000 W Chambers St, Milwaukee, Wis 53210.

Nov 16: *Green Bay One-day Seminar for Family Physicians,* at St Vincent Hospital. Further details later.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

September 5 - September 18

Clinical Immunology Update

—The Mechanisms of Immune Competence
—Immune Deficiency Disorders
—Autoimmune Diseases

Co-sponsored for Category 1 credit by the AMA Council on Continuing Physician Education. The telecourse faculty on this three-part program is Robert M Nakamura, MD, Chairman, Dept of Pathology, Scripps Clinic Medical Institutions, LaJolla, California and Ernest S Tucker, MD, Associate Clinical Professor of Pathology and Pediatrics, University of California School of Medicine, San Diego

September 19 - October 2

The Nephrotoxicity of Antibiotics and Antibiotics and Renal Failure with Harold C Neu, MD, Professor of Medicine and Pharmacology, and Head, Division of Infectious Diseases, Columbia University College of Physicians and Surgeons, New York.

The Insulin-Dependent Diabetic Patient: Two Unstable Episodes with Rubin Bressler, MD, Professor and Head of Internal Medicine and Professor of Pharmacology, University of Arizona College of Medicine, Tucson.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in most videotape and videocassette formats.

TRAUMA SYMPOSIUM

St Marys Hospital Medical Center Madison

September 30—October 1

in cooperation with University of Wisconsin-Madison Center for Health Sciences-School of Medicine and UW-Extension Health Sciences Unit, Dept of Continuing Medical Education.

Symposium co-chairmen: Louis C Bernhardt MD and James E Gutenberger MD, Dean Clinic and St Marys Hospital Medical Center.

Guest faculty: F William Blaisdell MD, Chief of Surgery Service, San Francisco General Hospital, San Francisco; Professor of Surgery, University of California School of Medicine; and Robert J Freeark MD, Professor and Chairman, Department of Surgery, Loyola University Medical Center, Maywood, Illinois

Faculty-UW Center for Health Sciences: Folkert O Belzer MD, Marvin L Birnbaum MD, and Dennis G Maki MD

Faculty-St Marys Medical Center: Louis C Bernhardt MD, Wojciech M Bogdanowicz MD, Richard J Botham MD, James E Gutenberger MD, Robert R Henderson MD, Ernest A Pellegrino MD, William Rock MD, George F Roggensack MD, J Michael Shannahan MD, Eugene E Skroch MD, George T Steinmetz MD, and Raul F Waters MD.

Fee: $50. *Credit:* AMA-PRA Category 1; AAFP applied for; CEHs by UW-Extension, Dept of CME.

Registration: CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

(Wisconsin-Northwestern Football Game, October 1)

INTERSTATE SCIENTIFIC ASSEMBLY

Hollywood, Florida
Diplomat Hotel

October 31—November 1-3

This program is designed for Primary Care Physicians practicing in the United States and Canada. It has been planned cooperatively with the Florida Academy of Family Physicians, the University of Miami and the University of Florida-Gainesville. It provides 26 hours of credit for members of the American Academy of Family Physicians. Also credit toward the AMA Physician's Recognition Award is provided through attendance.

The program consists of lectures, informal group discussions, "live" closed-circuit TV and medical movies on a variety of topics with major emphasis on infectious diseases, endocrinology, cardiovascular, nephrology, nutrition, and rheumatology.

Guest lecturers include: Dr Irvine H Page of the Cleveland Clinic Foundation on "Science and Intuition in Medical Practice;" Dr Ray Gifford of the Cleveland Clinic Foundation on "Hypertension Update;" Dr Robert W Kistner of Harvard on "Major Gynecologic Problems Associated with Oral Contraceptives;" Dr Walter Spitzer of McGill University, Montreal, Quebec, on "A New Look at the Value of the Periodic Health Examination;" Dr Joseph Hollander of the University of Pennsylvania on "Diagnosis of Painful Joints."

In addition there will be numerous other lecturers from the University of Florida-Gainesville and the University of Miami. The Thursday session will be devoted to "Medical-Surgical Update."

The Assembly is open to any licensed physician in the US and Canada for a fee of $75 in advance or $100 at the meeting. Those interested in the meeting and hotel forms should write to: Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701.

1978 WISCONSIN

Jan 19-21: *Winter Refresher Course for Family Physicians.* Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians. Pfister Hotel and Tower, Milwaukee. See details elsewhere in this issue.

Mar 30-Apr 1: Second Annual Ophthalmology Current Concepts Seminar '78 of the University of Wisconsin-Madison. Lectures and Workshops. Sponsored by the Dept of Ophthalmology Faculty, University Hospitals, Madison.

1977 NEIGHBORING

Sep 26-30: *Family Practice Review and Update—1977,* a continuing medical education course sponsored by the University of Minnesota, Minneapolis, at the St Paul Radisson Hotel. This annual, five-day course is designed to meet the needs of physicians preparing for certification or recertification in family practice, or those wishing a comprehensive general review. All major fields of medicine and surgery are presented in a systematic manner. Fee: $245. Approved for approximately 40 perscribed hours by the AAFP and AMA Category 1 credit.
Info: Office of Continuing Medical Education, Box 293, Mayo Memorial Bldg, 420 Delaware St SE, Minneapolis, Minn 55455; (612) 373-8012.
g6-8/77

Sep 29-30: *Recent Advances in the Care of the Aging Patient,* a clinical program on geriatrics sponsored by the Illinois State Medical Society's Committee on Aging, in cooperation with the AMA, to be held in Oakbrook, Ill. Sessions are aimed primarily at the general internist, family physician, neurologist, surgeon or psychiatrist with a special interest in geriatrics. Tuition for the two-day program is $150. Info: Illinois SMS, 55 East Monroe St, Chicago, Ill 60603; (312) 782-1654.
g6-8/77

Sep 30: *John R Sebald MD Memorial Hand Symposium,* at College of St Thomas, St Paul, Minn. Sponsored by Bethesda Lutheran Hospital in cooperation with the College of St Thomas. 8:30 am-5:00 pm. Approved for Category I credits, AMA, American Academy of Family Physicians, and ANA. Speakers: Joseph Kutz, MD, University of Louisville; Richard Burton, MD, University of Rochester, New York; Donald Serafin, MD, Duke University and Charles J MacDonald, MD, St Paul, Minn, will cover hand topics of interest to all practitioners, and will include tendon injuries, rheumatoid arthritis, finger tip injuries, neuropathies, and microsurgery. For program send to Chris P Tountas, MD, Bethesda Lutheran Hospital, 559 Capitol Blvd, St Paul, Minn 55101.
p8/77

Oct 15: CME Program: *Law for Physicians,* Thomas G Baffes, MD, JD, Moderator. Speakers: Harold Jacobson, Philip Corboy, John Hayes, and Howard Gilbert, attorneys; and Hon David Canel, Judge, District Court of Cook County. At Mt Sinai Hospital, 15th St & California Ave, Chicago, Ill

THE FINANCING OF MEDICAL CARE

10th Annual Workshop of the Institute of Medicine of Chicago

Continental Plaza Hotel, Chicago

Friday, November 11

8:00 am to 5:00 pm

Are consumer health care demands realistic in terms of actual health care needs?

How Will Rising costs in the financing of health care affect undergraduate and graduate medical education?

Governmental, academic and private insurance company solutions to these problems will be subjects for panel and general discussion along with advantages and disadvantages of "capping" hospital payments and other means of cost containment in every phase of health care.

Registration ($45 for nonmembers, $40 for members) includes luncheon and coffee breaks.

For information, write Institute of Medicine of Chicago, 332 South Michigan Ave, Chicago, Ill 60604, or call 312/663-0040.

CONFERENCE ON ANESTHESIOLOGY

FIFTY YEARS AFTER—

September 10-11, Madison
University of Wisconsin

The appointment of Ralph M Waters, MD to the faculty of the University of Wisconsin in 1927 marked the beginning of a new era in anesthesiology. During his two decades at Wisconsin, Doctor Waters was the vitalizing influence for the rapid development of the specialty in the United States and abroad.

This meeting recognizes the resulting contributions of Doctor Waters and celebrates the Fifty Years of Academic Anesthesia at the University of Wisconsin and the United States.

In addition, the conference will explore how the specialty will be influenced in the future by changes in technology, pharmacology, and society at large.

All sessions will be held at the Wisconsin Center, 702 Langdon Street, Madison.

Conference fee of $27 for members of the Wisconsin Society of Anesthesiology covers all coffee breaks, lunch on Saturday, and the banquet Saturday evening.

Conference fee of $62 for nonmembers includes the educational program, all coffee breaks, lunch on Saturday, and the banquet Saturday evening.

Faculty will include:

Henry Bendixen, MD
Professor and Chairman, Department of Anesthesiology, College of Physicians and Surgeons, Columbia University, New York, New York.

Edmund I Eger II, MD
Professor of Anesthesiology, University of California, San Francisco, Calif.

E S Siker, MD
Past President, American Society of Anesthesiologists

Leroy Vandam, MD
Anesthetist-in-Chief, Peter Bent Brigham Hospital, and Professor of Anesthesiology, Harvard University, Boston, Mass.

Credit: All courses offered by the University of Wisconsin-Extension, Department of Continuing Medical Education, are accredited by the American Medical Association for Category I credit.

Sponsored by the Wisconsin Society of Anesthesiology and University of Wisconsin-Madison, Center for Health Sciences, Department of Anesthesiology, in cooperation with the Department of CME, Health Sciences Unit, UW-Extension

Info: CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

University of Wisconsin-Madison Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

CME Calendar—1977

Sep 7: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Sep 10-11: *50th Anniversary Anesthesiology Program,* The Wisconsin Center, Madison. Fee: Members $27; Nonmembers $62.

Sep 13: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Sep 15-17: *Family Physician Refresher Course,* The Edgewater Hotel, Madison. Fee: $125.

Sep 21: *Maternal and Infant Care: Infant Assessment and Early Management,* Beaver Dam Community Hospitals, Beaver Dam.

Sep 30-Oct 1: *Hospital Administration,* The University Bay Center, Madison.

Sep 30-Oct 1: *A Conference on Dermatology,* The Wisconsin Center, Madison.

Sep 30-Oct 1: *Trauma Symposium,* St Marys Hospital Medical Center, Madison.

Oct 11: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Oct 19: *Maternal and Infant Care: Special Neonatal Problems I,* Beaver Dam Community Hospitals, Beaver Dam.

Oct 21: Annual Fall Pediatrics Day, *New Trends in Clinical Pediatrics,* at Howard Johnsons Motor Lodge, Madison.

Oct 25-28: *Educational Resources,* University Bay Center, Madison.

Oct 26-28: *50th Anniversary Preceptorship Program,* The Wisconsin Center, Madison

Nov 3: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Nov 3-5: *Interventional Radiology,* The Wisconsin Center, Madison.

Nov 8: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Nov 16: *Maternal and Infant Care: Special Neonatal Problems II,* Beaver Dam Community Hospitals, Beaver Dam.

Dec 21: *Maternal and Infant Care: Optional Assessment of Series,* Beaver Dam Community Hospital, Beaver Dam.

Info: Coordinator, Dept of CME, 601 Walnut Street, Madison, Wis 53706; phone: 608/263-2850.

60608. Preregistration fee: $40. Office of Medical Education (312) 542-2562. Approved for 5 hours of Category I credit for AMA-PRA. g8-9/77

Oct 26-28: *Rights of children as research subjects* will be argued in a conference at the University of Illinois at Urbana-Champaign. Sessions to be held at Ramada Inn, Champaign. Info: Ronald G Sears, Conference Director, 116 Illini Hall, University of Illinois, Champaign, Ill 61820. g6-9/77

1977 OTHERS

Sep 29-Oct 1: *National Conference on the Lymphomas and the Leukemias,* American Cancer Society—National Cancer Institute, Waldorf-Astoria Hotel, New York City. This CME offering meets the criteria for 15½ hours of credit in Category I for the PRA-AMA. Program is acceptable for 15½ elective hours by the AAFP. Info: Sidney L Arje, MD, American Cancer Society—National Cancer Institute, National Conference on the Lymphomas and the Leukemias, 777 Third Ave, New York, NY 10017. g4-8/77

Oct 5-8: Annual Meeting, American Group Practice Association, Houston, Texas. Info: AGPA, Educational Services Office, 20 S Quaker Lane, Alexandria, Va 22314. g8-9/77

Oct 17-22: *Eighth National Symposium and Workshop on Protecting the Abused, the Neglected, and the Sexually Exploited Child,* at the Sheraton Waikiki in Honolulu, Hawaii. Info: American Humane Association, Children's Division, PO Box 2788, Denver, Colo 80201. g7-9/77

Oct 31-Nov 1-3: *62nd Annual International Scientific Assembly of Interstate Postgraduate Medical Association,* at Diplomat Hotel in Hollywood, Fla. Further info: Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701. g6-9/77

Nov 4-5: *Conference on Cancer of the Bladder and Prostate,* American Cancer Society-Kentucky Division, at Stouffer's Inn, Louisville, Ky. Info: George A Sehlinger, MD, President, ACS-Kentucky Div, 2313 Medical Arts Bldg, Louisville, Ky 40217. g5-10/77

FIRST STATE MEETING: WISCONSIN CHAPTER OF THE

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Thurs-Fri, October 6-7/Marc Plaza Hotel, Milwaukee

Held in conjunction with the Emergency Department Nurses Association (EDNA)

CME credit value of approximately 12 hours/Category I

Program will include a development of emergency services in Wisconsin with emphasis on the EMS system in Milwaukee. This will be followed by a panel on the relationship of critical care medicine which will be chaired by Dr Marvin Birnbaum of the University of Wisconsin. Panel will be highlighted by participation of Dr William Shoemaker who has been a moving figure in this field among his notable accomplishments. At noon he will be the principal speaker highlighting the need for emergency medicine.

The afternoon panel will be principally devoted to cardiac care in the emergency department which panel will again be chaired by Dr Marvin Birnbaum.

On the following day there will be a panel on emergency department problems chaired by Dr CC Roussi who is the president of the Society of Teachers of Emergency Medicine. In addition there will be Dr Marshall Segal, a noted authority on the medical-legal aspects of emergency medicine and Dr David Wagner who has been involved in the development of the concept of emergency department residencies.

Folowing this panel will be a Dean's panel discussing the place of emergency medicine in this medical school curriculum. This panel will be chaired by Dr David Wagner and will have Dean Lawrence Crowley of the University of Wisconsin and Dean Gerald Kerrigan of the Medical College of Wisconsin and Dean Bernard Siegel of the University of Illinois.

At noon the keynote speaker will be Dr Roland Krone who is the national president of ACEP.

In the afternoon there will be a panel on abdominal trauma chaired by Dr Joseph Darin of the Medical College of Wisconsin. The two afternoon panels will have as their member participants faculty of the respective medical schools in this state.

In the afternoon there wil be 12 other subjects relating to emergency departments presented by selected roster of speakers. It also is planned to have a general membership meeting for the Wisconsin Membership.

Further information: Richard J Krill, MD, 8200 North Teutonia Ave, Milwaukee, Wis 53209; (414) 354-4546.

1977 AMA

Sep 16-18: AMA Regional CME Meeting. Tan-Tar-A Golf and Tennis Resort. Osage Beach, Mo.

Sep 30-Oct 2: AMA Regional CME Meeting. The Homestead. Hot Springs, Va.

Oct 7-9: AMA Regional CME Meeting. Sawmill Creek. Huron, Ohio.

Oct 30-Nov 4: AMA Regional CME Meeting. Honolulu, Hawaii.

Nov 10-11: AMA 16th National Conference on Physicians and Schools. Regency Chicago. Chicago.

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Dec 20-23: AMA National Leadership Conference.

Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

Mental Health of the Elderly: An Interdisciplinary Educational Session

September 15-16, Madison Sheraton Inn

Sponsored by Mendota Mental Health Institute, Bureau of Mental Health, Division of Community Services, State Department of Health and Social Services and the University of Wisconsin-Extension departments of Nursing, Programs on Aging, Mental Health and Continuing Medical Education.

Participants will include:

Board members and staff of 51,42 boards and their contract agencies. Staff associated with inpatient services for the emotionally disturbed and mentally ill elderly. Administrators and staff associated with inpatient, outpatient, hospital, home care and nursing home care of the elderly. Other professional specialists in community programs for the elderly, such as social service personnel, public health personnel, staff of commissions and councils on aging, staff of senior citizen centers. Professionals in community medical programs.

Detailed information will be sent to all physicians in Wisconsin or is available through Health Sciences. UWEX, 610 Langdon St, Madison, Wis 53706.

1978 OTHERS

Jan 28-29: Second International Glaucoma Congress, at Americana Hotel in Miami Beach, Fla. Being held in conjunction with Annual Scientific Assembly of American Society of Contemporary Ophthalmology, Jan 30-Feb 3. Info: Dr John Bellows, Director, 6 North Michigan Ave, Chicago, Ill 60602. g8-12/77

Jan 30-Feb 3: Annual Scientific Assembly of American Society of Contemporary Medicine and Surgery, at Americana Hotel in Miami Beach, Fla. Meets criteria for 40 hours of credit in Category I for AMA-PRA. Info: John G Bellows, MD, PhD, Director, 6 North Michigan Ave, Chicago, Ill 60602; (312) 236-4673. g8-12/77 ■

1977-1978 Madison In-Depth Teaching Programs

Preliminary Schedule

Nov 17, 1977—(Thursday) University Hospitals

Dec 21, 1977—(Wednesday) Madison General Hospital

Jan 19, 1978—(Thursday) St Marys Hospital Medical Center

Feb 15, 1978—(Wednesday) Methodist Hospital

FALL CANCER CONFERENCE

Sponsored by WCCC-ACS

UWEX-CME Department

Saturday, October 8, Madison

University of Wisconsin Hospitals
1300 University Avenue
Room 227, SMI Building

PROGRAM

Paul P Carbone, MD, Moderator
9 AM—*Immunotherapy—Melanoma:* Ernest C Borden, MD; Alan Coates, MD

10 AM—*Role of Diet in Cancer Etiology—Perspectives on the Saccharin Controversy:* Raymond R Brown, MD; George T Bryan, MD

11 AM—*Testicular Tumors:* Thomas E Davis, MD; William L Caldwell, MD

12 N—Lunch: UWH Cafeteria
For registration, contact the American Cancer Society: (608) 249-0487. Registration fee: $5.00 includes coffee break and lunch.

For information about tickets to the Illinois-Wisconsin football game, contact the American Cancer Society.

CONTRIBUTIONS—CES FOUNDATION June 1977

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for June 1977.

Unrestricted

Fond du Lac, LaCrosse, Marathon, Grant, Outagamie, Winnebago and Dodge County Medical Society Auxiliaries; Richard W Biek, MD; Robert D Heinen, MD—*Voluntary Contributions*

Restricted

Merck and Co, Inc—*Speakers Service*
Merck and Co, Inc—*Guest Speakers*
Falls Medical Group—Menomonee Falls; Medical Associates—Baraboo; East End Clinic—Superior; Park Medical Center—Manitowoc; CB Moen, MD; WE Rosenkranz, MD; RE Jensen, MD; James Albrecht, MD; Forrest E Zantow, MD; New Richmond Clinic; Roy B Balder, MD; Chetek Medical Clinic; Marinette-Florence County Medical Society; Portage Clinic; Francis Gilbert, MD; Spooner Clinic; Red Cedar Clinic—Menomonie; Riverwood Clinic—Wisconsin Rapids; Indianhead Chapter; Wisconsin Rural Rehabilitation Corp; Marathon County Medical Society—*Medical Student Summer Externship Program*
Membership Dues—*Aesculapian Society*

Memorials

State Medical Society—*William E Buckley, MD; Wallace L Nelson, MD; Eleanor Delfs, MD; William J Egan, MD*
Paul G LaBissoniere, MD—*Robert D De Cock, MD*
Dane County Medical Society—*Charlotte J Calvert, MD*
Elnora Hayes Johnson—*Vera Hub*
Mr-Mrs Donald B Idzik—*Roland Barnum* ■

PHYSICIANS, REMEMBER THESE DATES FOR FILING MEDICAID CLAIMS

On July 1, 1977 EDS Federal Corporation took over the administration of the Medicaid (Title 19) Program in Wisconsin. It is important that physicians remember the following dates concerning the filing of claims:

Sept 30, 1977—All claims for Medicaid services rendered *prior* to July 1, 1977 must be filed with Wisconsin Physicians Service (WPS) Insurance Corporation before this time in order to be reimbursed.

July 1, 1977—All claims for Medicaid services rendered *after* this date must be filed with EDS Federal Corporation in Madison. Direct physician claims to Suite 500, Medicare cross-over claims to Suite 700, and all other claims to Suite 800; zip code: 53784.

Aug 31, 1977—All claims for Medicaid services up to *two years old* must be filed by this date. After this time, only claims one year old will be accepted. Out of date claims must be submitted with evidence such as remittance advice notice, rejected claim copy, or other documents.

Additionally, physicians should continue to submit claims for services rendered to patients who have both Medicaid and Medicare to either WPS or Surgical Care for processing of Medicare coverage first. These Medicare intermediaries will then automatically refer these claims to Medicaid/EDS after Medicare processing is complete.

Recently the State Department of Health and Social Services and EDS Federal Corporation sent a "provider information form" to all physicians. It is imperative that physician providers promptly complete and return this form so that EDS can update provider addresses and Medicaid members. This will assure that future payment checks and other mailings will go out on time and to the correct addresses. Physicians who have questions regarding implementation of the new Medicaid procedures should contact the State Medical Society, Physicians Alliance Division, Box 1109, Madison, Wis 53701. Any questions regarding the filing of forms can be answered by calling toll free to EDS: 800/362-9111.

NEW HEW REGULATIONS ON HANDICAPPED PATIENTS

Under new HEW regulations, physicians who receive Medicare and Medicaid funds will have to insure handicapped patients equal access to federal health benefits. The Rehabilitation Act requires that Medicare and Medicaid providers make "other arrangements" for handicapped patients who are physically unable to reach the physician's office. A private physician in solo practice would have to meet the handicapped patient in an accessible place, such as a hospital or clinic, refer the patient to another physician, or meet the patient at the patient's home. In addition, outpatient facilities with 15 or more employees will be required, within three years, to structurally alter their facilities if they contain barriers to the handicapped that cannot be overcome by other means. The regulations also give the HEW Office of Civil Rights the authority to require a physician to provide "auxiliary aids" for the handicapped. Written notices that a doctor sends to sighted patients must be transcribed into Braille (or broadcast on the radio) for blind patients. A physician also must make sure a waiver of rights or a consent to treatment is presented in a way that is understandable to a blind, deaf or mute. These regulations are mandatory for providers with 15 or more employees.

FETAL ALCOHOL SYNDROME SYMPOSIUM SCHEDULED

The Wisconsin Association on Alcoholism and Other Drug Abuse will hold a Fetal Alcohol Syndrome Symposium to discuss prevention, intervention, and treatment implications for the mother and child. The symposium, scheduled for October 31 at the Madison Sheraton Inn, will feature guest speakers Henry Rosett, MD of the University of Boston Medical School and Ann Streisguth, MD of the University of Washington School of Medicine.

CERTIFICATE-OF-NEED INFORMATION MAILED TO PHYSICIANS

Physicians should now have in their offices application forms and procedures for the "certificate-of-need" program which went into effect June 30, 1977. Physicians are reminded that if they signed any contract for the purchase of any equipment covered under the CON law after June 30, 1977, they must complete the CON application process or face possible rejection of the purchase. DHSS is considering conducting workshops on the certificate-of-need process for physicians and/or clinic managers. The State Medical Society will contact physicians as soon as these are arranged. Physicians having questions concerning the CON process should contact the SMS Physicians Alliance staff at 608/257-6781.

WORK WEEK OF HEALTH SET FOR OCTOBER 18-19

Wisconsin high school seniors will have an opportunity to learn how to prepare themselves for life after high school during the Wisconsin Work Week of Health scheduled for Tuesday, October 18, in Eau Claire and Wednesday, October 19, in Winnebago. Further details appear in the SMS ORGANIZATIONAL section of this issue.

SMS OFFERS MEMBERS A SOUTH AMERICAN ADVENTURE

The State Medical Society is offering its members and their spouses a winter travel opportunity —a South American Adventure! An announcement appears in the SMS ORGANIZATIONAL section of this issue. Further communications regarding trip will be sent to the SMS membership soon.

WATCH FOR TV PUBLIC SERVICE ADS

The SMS Communications Department, in cooperation with the American Medical Association, presently is distributing a set of three public service advertisements to commercial television stations in Wisconsin. The 30-second messages each carry a "tag" indicating that the sponsors of the message are physician members of the State Medical Society. The messages, which will be aired free by the stations, deal with the importance of physical fitness, venereal disease, and blood donation.

AMA REAFFIRMS POSITION ON MARIHUANA

The American Medical Association once again has asserted its 1972 position that the penalty for marihuana for personal use by individuals should be at the most a misdemeanor. Testifying before the Select Committee on Narcotics Abuse and Control, AMA spokesman Herbert Raskin, MD, also said that while the AMA favors reduction in the penalty for possession of marihuana, it does not favor legalization of the drug. Doctor Raskin gave the following reasons for the AMA's position: (1) Marihuana is an intoxicant and may have undesirable psychological effects; heavy use of the drug tends to represent a psychological dependence upon it and medical treatment is indicated. (2) The use of marihuana decreases psychomotor coordination on a dose-related basis. There also is evidence that marihuana use can adversely affect the ability to drive a motor vehicle. (3) Many research studies have raised questions concerning the possible effect of marihuana upon the body's immune mechanisms, testosterone levels in males, and other biological functions. (4) If marihuana were legalized, it would only be a short time before sophisticated advertising techniques would be employed to encourage the frequent and widespread use of marihuana.

TWO WISCONSIN JAILS RECEIVE ACCREDITATION APPROVAL

The American Medical Association's Jail Health Project has given preliminary approval for accreditation to two Wisconsin jails, Eau Claire and Milwaukee. See further details in the SMS ORGANIZATIONAL section of this issue. ■

the wisconsin medical journal

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FROM THE PRESIDENT

Membership Goal: 100% Involvement

THE CLEVERLY-WRITTEN editorial on county and state society membership by Doctor Wayne Boulanger in the July issue of The Journal deserves to be read again. Unfortunately, the majority of readers will be those members who have paid their dues and take an interest, if not active, role in medical affairs. Physicians who are non-members benefit equally from the gains made through organized efforts.

The Society is presently launching a recruiting program, detailed elsewhere in this issue, with individual mailings to non-member physicians in the state. While we have shown a gain in membership during the past year, our real goal is 100% involvement by all physicians. Dissent is to be expected among members of any large group. Satisfactory solution of such dissent can only be accomplished by reason and discussion. No solution is possible without dialogue.

Activities of the Commission on Governmental Affairs and the Physicians Alliance Commission amply demonstrate legislative effectiveness. Our collective voice carries an impact on health measures never before achieved. Benefits have accrued to all physicians as a result of organized efforts, in sharp contrast to what might have been attained with individual physician voices crying in the wilderness.

If the goals in our state can be accomplished, our voice on the national level will be more clearly heard. We all know that we will have a National Health Plan. If we fail to participate in planning, we cannot expect to have a voice in the final plan. To quote Walter McClure again, "In the area of national health insurance, the issue isn't whether there will be change or no change—it's what change will occur and who will lead it."

If we are to ensure the quality of medical care, and the provision of such care in a fashion acceptable to us as physicians, we must provide a unity of effort. Even if it hurts, we must, as citizens and physicians, keep in mind the larger views and larger obligations we have assumed as professionals.

Roy B Larsen MD

LATE FLASH!

The State Assembly, September 20, approved 56-39 Senate Bill 108 that would require all health insurance policies issued in the state to provide coverage for chiropractic as well as physician services. The measure now goes to the Governor who is expected to sign it. SMS lobbyists reported the presence of about 40 chiropractors who expressed jubilation in the halls surrounding the Assembly chambers after the victory.

Chiro clout

THERE ARE ONLY approximately 500 chiropractors in the state, and during the 1970s they have enjoyed consistent political success. They have succeeded in becoming "providers" of care under the Worker's Compensation program, Medical Assistance, and optional private health insurance coverage. Currently there is Senate Bill 108 which proposes to mandate chiropractic services under *all* insurance policies sold in Wisconsin.

In addition, the Medical Practices Act of 1976 allows chiropractors to use the title "doctor" as long as it is qualified by the initials "D.C." or Doctor of Chiropractic following the name. The 1977-79 State biennial budget also statutorily defines them as a "provider" in the Medical Assistance program, a move which may prevent the Department of Health and Social Services from deleting their services from Medical Assistance by administrative rule.

Although the State Medical Society and most insurance companies are strongly opposed to the Senate Bill 108, it really does not have direct bearing upon physicians or their practices. The real danger is that if chiropractors were to be automatically covered under all health insurance policies, and in view of their past political and legislative successes, the next step inevitably is that they be granted access to hospitals and clinics. Undoubtedly, the hospital privileges demand will be the next legislative proposal by the chiropractors.

Consider the following five points and the legislative successes of the chiropractors and their lobby are understandable:

(1) The relatively small number of chiropractors are well organized and easily mobilized during election years.

(2) Campaign contributions from chiropractors are usually large and are always individual, private contributions. There is no chiropractic counterpart to WISPAC.

(3) Chiropractors are extremely active campaigners. They campaign "door-to-door" for their endorsed candidates, put campaign literature in their offices, communicate personally with their patients about endorsed candidates and using these same techniques, actively oppose candidates who are likely to oppose them in the Legislature. (Physicians have been advised by legislators to learn a lesson from the chiropractic campaigners.)

(4) The practice of chiropractic, ranging from the scope of their practice to their payment by public and private health plans, is *totally* reliant upon the Legislature. Their practices and their futures depend solely upon legislative action.

(5) Chiropractors generally employ a technique best described as a "one issue per session" approach to the Legislature. They pick an issue as a priority item for each two-year session of the Legislature and really concentrate on it with their time, money, and manpower. This is quite a different situation from the State Medical Society which must monitor and follow some 500 pieces of legislation each session.

How would your hospital staff react if in the next biennium, an application for staff privileges was submitted by a local chiropractor? It behooves all Wisconsin physicians to develop some clout of their own, either as individuals or through WISPAC.—VSF

Gut issue—AB 784

"GUT ISSUE" seems to be an appropriate sequel to "Intestinal Fortitude" and "Borborygmus" (August WMJ). The issue is Assembly Bill 784 in which drastic changes are proposed in licensing laws for Wisconsin.

AB 784 creates a three-person Occupational Standards Board (OSB) appointed by the Governor and chaired by the Secretary of the Department of Regulation and Licensing. The OSB would be the "super-board" for the licensing and regulation of *all* occupations and professions in Wisconsin. Examining boards which survive the proposed cut, including the Medical Examining Board, would exist as advisory bodies to the OSB for purposes of rule development and determination of examination policies. The membership of the OSB would consist of the Secretary of regulation and licensing, plus two public (non-medical,

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ACCREDITATION MANUAL FOR HOSPITALS

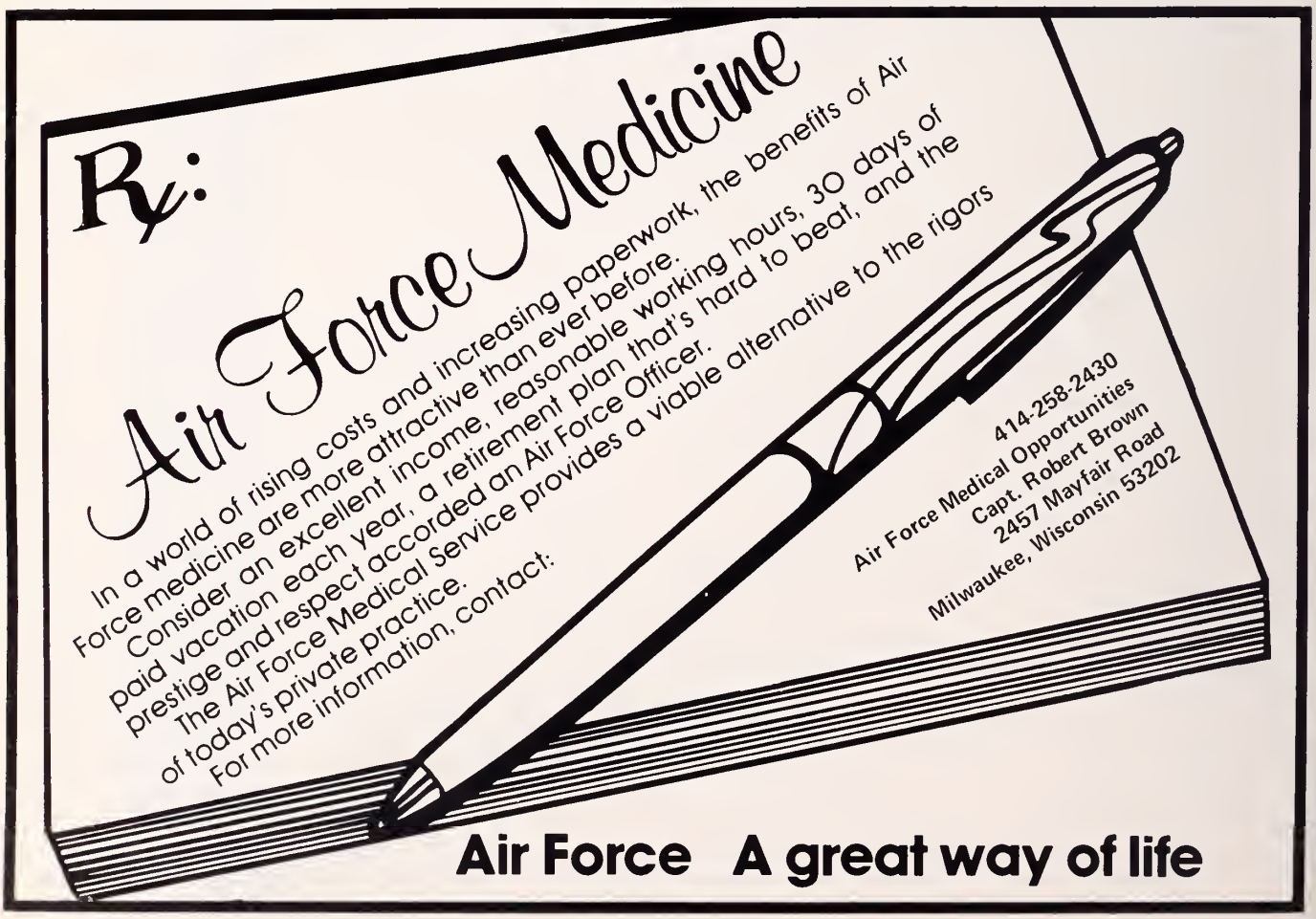
The 1976 edition of the *Accreditation Manual for Hospitals* contains Joint Commission on Accreditation of Hospitals (JCAH) standards for general acute-care hospitals, covering 22 areas of hospital operation. The *Manual* was first published in 1971 and is updated as often as necessary to meet the needs of the field. It is available for $7.50 in soft-cover, 3-holed punched and perforated for easy removal and insertion in 3-ring binder. Also a *Supplement to Accreditation Manual for Hospitals* (1977) is available for $4.00 when purchased singly. The *Supplement* is automatically included in the purchase price of the *Manual.*

The purpose of the *Accreditation Manual* is to provide principles and standards for hospital governing boards, medical staffs, and hospital service departments in establishing efficient operations to give the best care to the patient, maintaining safety always in the most reasonable and efficient manner.

New features of the *Manual* include new standards sections for: Building and Grounds Safety, Functional Safety and Sanitation, Infection Control, and Quality of Professional Services, and revisions in many standards sections. The *Supplement* includes new standards for utilization review; new standards for institutional planning; revisions in medical staff, governing body and management standards; and an expanded glossary.

Attention also is directed to *Guidelines for the Formulation of Medical Staff Bylaws, Rules and Regulations 1971,* one for departmentalized hospitals and the other for nondepartmentalized hospitals. Each has numbered lines for ready reference and wide margins for notes or modifications in suggested language. Each publication is priced at $5.25.

Copies of the manuals referred to above are available from the Joint Commission on Accreditation of Hospitals, 875 North Michigan Ave, Chicago, Ill 60611. It is *required* that all orders, except government orders, be prepaid.



non-health) members appointed by the Governor. The OSB would also function as an appeal board from disciplinary decisions of an examining board. In that function, the Secretary would be replaced by a third public member.

The OSB represents an extension of the cabinet form of government in its least desirable form. Its proponents allege it will increase accountability. In fact, it will only increase bureaucracy by the insertion of another and unnecessary layer of part-time political appointees. The rule-making process is already subject to public hearings and then to a 30-day overview by a joint Senate-Assembly review committee. Appeals from disciplinary decisions may now be taken either through the Chapter 227 process or the judicial route. Centralization of the administrative functions of regulation and licensing has already been mandated to the Secretary by acceptance of the 1977-78 budget bill.

There is literally no need for a new layer of political appointees in the regulation and licensing process except for the doubtful purpose of political patronage.

The situation has often been bad enough in the past when physicians who have had the least experience in actual practice are the most vocal in regulating and suggesting changes for their more clinically productive peers. (Of course, this does not apply to the State Medical Examining Board.) But the situation would certainly be much worse if a group such as that proposed in AB 784 would be considered qualified to judge professional examination and competence issues. And this ends our series through the intestinal tract.—VSF ■

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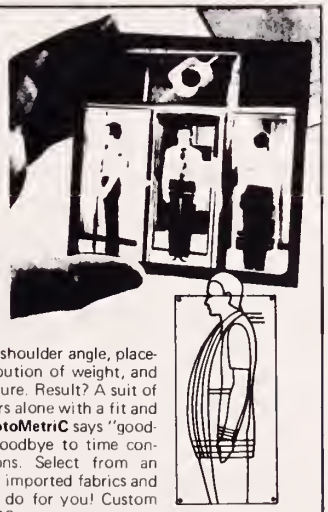

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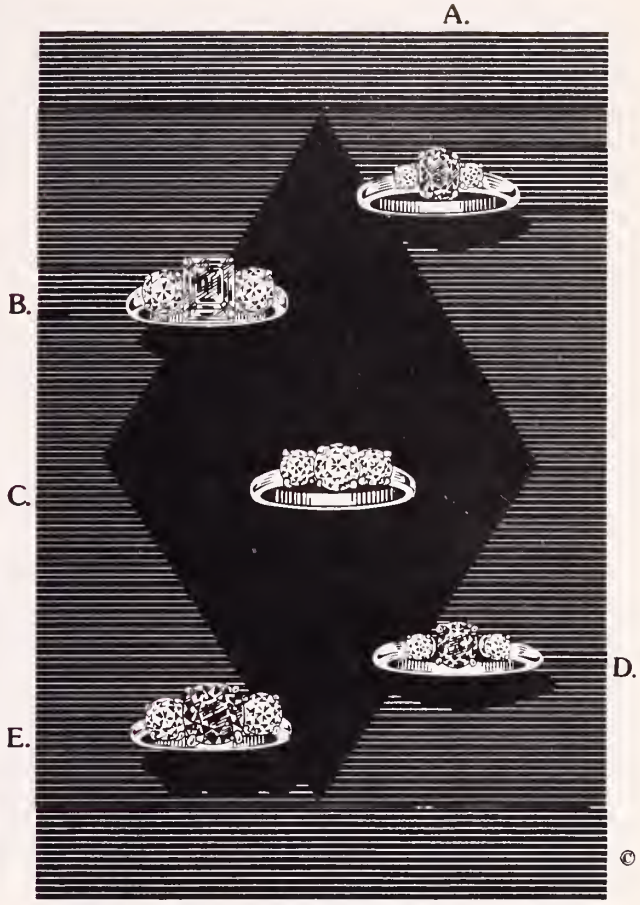

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September 1977 through November 1977

STATE DEPARTMENT OF PUBLIC INSTRUCTION

DIVISION FOR HANDICAPPED CHILDREN

Bureau for Crippled Children

Location	*Date*	*Examiner*
Eau Claire	Sept 29	Claude Davis, MD
Chippewa Falls	Oct 6 (PM)-7	AJ Ficke, MD
Racine	Oct 12	CW Christenson, MD
Kenosha	Oct 13	AA Patel, MD
Ashland	Oct 27-28	JD Chambers, MD
Rhinelander	Nov 3	HI Okagaki, MD
Darlington	Nov 10	GH Vogt, MD

FOR: Clinics conducted by the Bureau for Crippled Children are for persons under 21 years of age for orthopedic diagnosis and consultation. Reports of the examinations are sent to the family physician following the clinic.

REFERRAL FORMS: May be obtained from the Bureau for Crippled Children and should be requested well in advance of the clinic date. Referral forms are made for each clinic so when requesting be sure to state how many are needed and for which clinic. It is important that we know in advance the number desiring clinic service so the caseload will not exceed clinic facilities. WE WOULD APPRECIATE HAVING ON THE REFERRAL FORM WHY THE CHILD IS BEING REFERRED TO CLINIC.

CLINIC APPOINTMENTS: Families who return the referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

NOTE: We no longer require the signature of a physician on the referral form. We would appreciate, however, the name and address so we can send the report to him.

ADDRESS CORRESPONDENCE: Bureau for Crippled Children, 126 Langdon Street, Madison, Wisconsin 53702.

Brief Summary

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M. pneumoniae — For respiratory infections due to this organism.

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Treponema pallidum—As an alternate treatment in patients allergic to penicillin.

C. diphtheriae and C. minutissimum—As an adjunct to antitoxin. In the treatment of erythrasma.

Entamoeba histolytica—In the treatment of intestinal amebiasis.

L. monocytogenes—Infections due to this organism.

Establish susceptibility of pathogens to erythromycin, particularly when *S. aureus* is isolated.

Contraindications:

Known hypersensitivity to erythromycin.

Warnings:

Safety for use in pregnancy has not been established.

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Donald Chisholm, MD, Milwaukee (5)
John U Peters, MD, Fond du Lac (6)
Harold J Kief, MD, Fond du Lac (6)
Michael P Mehr, MD, Marshfield (7)
Vacancy (8)
Carl Eisenberg, MD, Milwaukee (9)

EX OFFICIO

Joseph M Lubitz, MD, Oconomowoc
Chairman, Commission on Governmental Affairs

Mrs LaVern Herman, Waukesha
Auxiliary Legislative Chairman

(Council has approved formation of a new subcommittee of GAC—Committee on Environmental Health)

IN PERSPECTIVE

THIS MONTH'S ISSUE of the *Wisconsin Medical Journal* marks the beginning of a new monthly feature devoted to legislative and political issues of interest to all Wisconsin physicians . . . IN PERSPECTIVE. These columns will attempt to keep all readers informed of the "political philosophy" behind actions taken by the State Medical Society regarding legislation affecting health care in Wisconsin. It is especially important that such information and viewpoints be made available to Wisconsin physicians because nearly 20% of the 2,500 legislative proposals introduced during the session deal in one way or another with health care.

LUBITZ

Actions taken on behalf of SMS on these legislative proposals originate in two physician commissions of the State Medical Society—the Commission on Governmental Affairs (GAC) and the Physicians Alliance Commission (PAC). The PAC has been charged by the SMS House of Delegates with specific responsibility in the areas of professional liability and medical assistance, while the GAC deals with all other issues. The GAC "scope of coverage" is especially wide, dealing with health planning, financing, and implementation plus the many "traditional" issues such as the practice of optometry, chiropractic, podiatry, and others. In addition, the GAC has recommended the introduction and passage of several bills developed by SMS in the areas of preschool immunizations, genetic testing, certificate-of-need, and others.

The intent of this monthly communication is not to advise physicians on how to affect the political process via legislative contacts. That task is borne by the weekly publication, *Capitol Week,* which is prepared by the Physicians Alliance staff and sent to those physicians, auxiliary members, and others who have agreed to serve as "legislative contacts." Rather, this feature will be devoted to explaining the rationale behind the decisions of the GAC and PAC and the general approach taken by SMS in dealing with government—an approach that initially can be described as one of negotiation and discussion with government and its officers and of providing constructive alternatives to proposals with which SMS finds disagreement. As chairman of the Governmental Affairs Commission, I speak for the entire Commission in saying that this approach has led to the beginning of a new era in SMS's relationship with not only the Legislature but also with the Executive Office, the Department of Health and Social Services, and other state agencies involved in health-related matters. As an example of how this new "era" in SMS political activity is developing, I urge your review of the interview with the Division of Health Administrator Ralph Andreano which appeared in the August issue of the *Wisconsin Medical Journal* and is concluded in this issue.

In the coming months this column will discuss the positions taken by SMS on major health issues. The next column will be authored by Kenneth Viste, MD, chairman of the Physicians Alliance Commission, who will discuss the PAC's activities and legislative proposals dealing with professional liability. (A listing of the PAC members will be included next month.)

Any questions regarding this column or legislative matters can be directed to the Physicians Alliance Division of the State Medical Society of Wisconsin at 608/257-6781, extension 115.

—JOSEPH M. LUBITZ, MD,
Oconomowoc ■

Physicians! These people are at your service
PHYSICIANS ALLIANCE FIELD CONSULTANTS

LOIS RILEY

Field Consultant
District 1

● Lois Riley, 40, has been the field consultant to the Medical Society of Milwaukee County since July of 1976. Before joining the Alliance, Lois worked as a member of the Laboratory Processing Team at Columbia Hospital in Milwaukee. Lois has been active in Milwaukee politics, has held offices in the League of Women Voters, and was elected to the City of Milwaukee School Board in 1975. Lois has been involved in several community activities including the Milwaukee Emergency Care Task Force and the Milwaukee County Anti-Rape Council.

KENNETH OPIN

Field Consultant
District 2

● Kenneth Opin, 36, field consultant to South Central Wisconsin, joined the Alliance Staff in July 1976. From 1964 to 1966 Ken served as Peace Corps Volunteer in Iran. Ken had worked in a variety of public relations and communications positions, the most recent being Communications Director with the Eunice Kennedy Shriver Center for Mental Retardation in Waltham, Massachusetts. In 1975-76 he worked as part of the national staff of the Morris Udall for President campaign.

MICHAEL BROZEK

Field Consultant
District 3

● Michael Brozek, 25, field consultant to the Northeastern District, joined the Alliance staff following service as an administrative assistant to Attorney General Bronson LaFollette. Mike's political involvement came in 1969 when he became chairperson for the Price County Young Democrats. Mike was a Wisconsin delegate to the 1976 Democratic Convention. With a major in political science and journalism, Mike produced and directed TV broadcasts for WSUR-TV and worked as a newsman for WSUR Radio in Eau Claire.

MARK MENDELSON

Field Consultant
District 4

● Mark Mendelson, 27, is the new field consultant to the Western District. Mark came to the Alliance staff in July 1977 from Lt Governor Martin Schreiber's office. Recently he completed graduate studies at Marquette University, Milwaukee. His political experience includes serving as deputy field coordinator for the Carter-Mondale Presidential Campaign in Wisconsin. He also has been active in the Milwaukee Jewish Council Anti-defamation League and the Jewish Community Center of Milwaukee.

MARVIN STROMER

Field Consultant
District 5

● Marvin Stromer, 41, field consultant for the North Central District, holds a PhD in political science from the University of Nebraska. Marvin was a member of the Nebraska State Senate from 1961 to 1967. Before joining the Alliance in November 1976, Marvin was dean of Milton College in Milton, Wisconsin. In 1970 he was director of the Ambassadorial Research and Foreign Policy Seminar for Europe, the Soviet Union and North Africa.

FIVE PHYSICIANS ALLIANCE DISTRICTS

The goal of the Physicians Alliance is to motivate, activate and involve physicians in returning to their proper place in the mainstream of health-care policy formulation and in personal involvement of health-related activities of their communities. The Alliance Field Consultants are there to help physicians at the local and county levels achieve this goal.

Wisconsin leaders talk about health care

This is a continuation from the August issue, of the interview with Ralph Andreano, PhD, administrator of the Wisconsin Division of Health. —A project of the SMS Communications Department.

Q. In this day and age when physicians are expected to meet certain conditions because of their participation in the federally funded health-care programs, I wonder if the same concept might be valid for the recipients of those programs.. Take, for example, the area of immunization and screening . . . isn't it fair to expect the recipients of these tax-funded programs to accept responsibility for immunization and screening?

A. The screening process has been a poorly thought out program in this state. EPSDT (Early Periodic Screening, Diagnosis, and Treatment), for example, is just on the margin of meeting federal requirements. As for its potential impact, both in terms of patient care and in terms of future taxpayer dollars, it's been rather poorly done in this state and all other states. That's one of my really top priorities; and I've already made some major changes in the WIC program (women, infant and children's program), which I consider a health program because it's basically a feeding program.

Bill Schatz made some major changes in that program in this state and we're just beginning to realize the fruits of those changes. I'm about to do the same for EPSDT. What those programs lack, by and large, is excellent management; and it just takes a long time to get the right managers in place and the right philosophy and the right data. We've been somewhat hampered in our EPSDT efforts in this state by the quality of the previous fiscal intermediaries' data availability with which we had to work.

Under the new Medicaid contract for claims processing with EDS-Federal, we're going to have for the first time an excellent tickler system on EPSDT where we'll fully comply with notification, follow-up, referral; and that coupled with improvement in our own management at the state level and the kind of technical management capability we give to the colonies or other agents through which we execute EPSDT programs should really have some impact.

RALPH ANDREANO, PhD

"As for its (EPSDT) potential impact, both in terms of patient care and in terms of future taxpayer dollars, it's been rather poorly done in this state . . . That's one of my really top priorities."

Of course, I am also excited and enthusiastic about our checkpoint immunization law which deals with non-Medicaid, or deals with the total population, and I am also enthusiastic and excited about CHAP (Comprehensive Health Assessment Program) which is a wider screening activity than just EPSDT. President Carter has put himself on the line for that program, and we in effect have a grant proposal in for that.

Q. Those programs have such a long tail; the cost benefit is a long time in approval.

A. Yes, but I think most of the studies have shown that for immunizations, for example, the benefit-cost ratio is extraordinary; and if we could fully implement the checkpoint immunization law in this state (after all it's been in effect a year), we could really tighten it this year. If we could really implement that, the benefit-cost ratio on the seven basic immunizations we've talked about would be extraordinary. That has to result, not

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today but 5 to 10 years from now, in reduced tax dollars for at least those diseases and the complications of those diseases.

Q. What is the Division's overall role or mission in the area of quality assurance, continuing high medical care?

A. Well I think it's fairly limited in that respect because most of our quality assurance efforts are really directed toward nursing homes and less toward what physicians do in their own individual offices. Sixty percent of all our Medicaid funds are for patients in nursing homes. Governor Schreiber, now and when he was Lt Governor, expressed strong concern about standards of quality in our nursing homes. While I am sure we are better than most states, we still have a long way to go.

"The problem I have with quality assurance review at the moment is that at the federal level the PSRO law, which has many good parts, takes away from me as the administrator, say of the Medicaid Program, a lot of power to be able to hold or withhold payment to providers . . . What I am looking for is some way to monitor what the PSROs do."

A lot of the federal programs that have been mandated for so-called independent professional review and IMR, IPR, UR and all these happenings we've used, are addressed toward trying to insure some kind of minimum level of quality. Nationally we're a long way from that and in Wisconsin we've made some progress and, I think, upping the level of quality care; but we still have a long way to go . . . and, of course, that's costly.

Q. Do you remember the health symposium (sponsored by SMS, DHSS, and the Wisconsin Center for Public Policy) in which you participated?

A. Yes.

Q. Doctor Blake Waterhouse talked about WHCRI (Wisconsin Health Care Review, Inc). He said that it is a consumer-oriented, multidisciplinary organization with the ability to take care of quality assurance for medicine, pharmacy, and dentistry . . .

A. Well, we have used WHCRI on occasion; I think we have some contract with them at the moment for reviews of one kind or another.

Q. What do you think? Is the state hesitant to use private sector quality assurance review?

A. No, I wouldn't say we're hesitant to use WHCRI. The problem I have with quality assurance review at the moment is that at the federal level the PSRO law, which has many good parts, takes away from me as the administrator, say of the Medicaid Program, a lot of power to be able to hold or withhold payment to providers. Also because the law says that the PSRO case is certified, it has to be paid. Now, I have less trouble with that with respect to hospitals because most of the PSRO activity there is done through delegation, but I have a great deal of trouble thinking about that with respect to nursing homes. What I am looking for is some way to monitor what the PSROs do. The law doesn't give me a great deal of leverage or a great deal of discretion in doing that. I have no reluctance to use PSROs but I feel that I ought to be given at least the opportunity to monitor what they do in a more systematic way than just simply saying that that's what the law says and that's what it is. That's one of the reasons I've been reluctant to sign the memorandum of understanding with the PSROs in this state.

Q. To be very honest with you, one of the things we hear from the PSROs is that both FMCE and WisPRO believe the Division of Health has plans to set up a division, one comparable organization to a PSRO.

A. No, we already do this for nursing homes because the federal law mandates it.

Q. The levels of care, what are called the independent professional review . . .

A. We already do that, and we use WHCRI and we have used

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them from time to time to do some of that for us. The law doesn't say that we have to give that up. We don't have any plans to do equivalent peer review by having state physicians, say for example in the hospitals, we don't have any plans to do that. I'm reluctant to give up anything, any influence or any chance to affect the structure, the cost and the quality of care in nursing homes. That's my greatest concern. It's not that we can't work with the private sector or that we can't get along or that we don't trust them or anything like that. The facts are that PSROs can't, by taking away some of my leverage with nursing homes, exert the kind of pressure I want to exert. So my intention is to continue to do our IPRs and IMRs until the federal government makes it clear that they are not going to pay for us to do them anymore. But we think we can do those equally as well through our system as through delegation to the nursing home with supervision, say by the PSRO.

Q. Well, is there anything else you want to add?

A. I would really like to say a couple of things about this transition we're going through in the Medicaid Program. As you know we recently made a rather dramatic, and in a very short period of time, transition to an entirely new fiscal intermediary for the Medical Assistance Program—EDS-Federal—and we've also been working carefully and successfully with the old fiscal intermediaries to have a smooth transition for all claims for dates of service prior to July 1.

There have been some problems, not so much with the physician community, but there have been some problems. The receptivity around the state is good. We need some patience and we need some time. And we are prepared to answer as quickly as we can all questions. The direction we are going is the direction we believe is in the best interest of the state, the best interest of providers, and the best interest of the recipients whom after all the program is supposed to benefit. We intend to put every policy of the Medicaid Program in writing. We intend to have everything in administrative rules. We intend to be above board and open with full disclosure of our payment practices and policies. As you know with respect to physicians we've gone completely to the Title 18 principles of reimbursement which we think is what physicians in the state wanted all along, though it still doesn't address two concerns I have; namely, about how we deal with some discrepancies in fees between physicians in rural areas and physicians in urban areas, nor does it fully deal with some discrepancies between fees in specialties. But we are going to try to address (we can't address every issue at the same time) all these issues a piece at a time. I welcome the input, the cooperation, and the participation of physicians in the state during this period of transition. We believe that payment is going to be prompt, efficient, and accurate—perhaps for the first time. We just ask for physicians' forbearance and patience until we get it all together. We are really trying hard to make the Medicaid Program an excellently well-managed program.

"We intend to put every policy of the Medicaid Program in writing. We intend to have everything in administrative rules. We intend to be above board and open with full disclosure of our payment practices and policies."

Q. Do you have any crystal-ball types of things so far as new directions for the transitions of the DHSS Secretary and the Governor?

A. Well, I think I'm just extraordinarily impressed with Secretary Percy. I think he is very sympatrical in what we want to do. He is himself management-oriented and I think the sort of things we are trying to do in Medicaid as well as other parts of the Division of Health are things that have his enthusiastic support. Governor Schreiber also is enthusiastically supportive of what we are doing, and I think you know he has had strong interests especially in nursing homes but in the Medicaid Program generally.

I think we are under the gun, me as the administrator, really under the gun to get the program turned around and well managed because I don't think Governor Schreiber would stand for anything less than that. So I think the crystal ball shows that the Governor and the Secretary are really committed to good management that is responsive to the objectives of the program and what they ought to be. I don't think the Governor will tolerate administrators who do not produce for him whether they are the Administrator for the Division of Health or the Secretary of the Department of Health and Social Services. ■

American Association of Medical Assistants, Inc.

Wisconsin Society

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Professional development & advancement seminars: 1977-78

THE AMERICAN Association of Medical Assistants, Inc-Wisconsin Society is again sponsoring two Professional Development and Advancement Seminars for the coming year. These seminars are open to participation by all medical assistants as well as medical assistant faculty and students.

As in previous years the seminars will be held in two locations of the state to enable us to reach as many people as possible. Both seminars will be held on Saturdays in order to allow attending without impingement on job responsibilities. This year we will offer the Mini-test which is a preparation for the Basic Certification Examination and continuing education units will be offered.

The seminar at Stevens Point, November 12, 1977 will offer the following programs. The morning session will include the mini-test and a presentation by Bernie Maroney of the State Medical Society on "Closing of a Medical Office, the Medical Record and Telephone Information." In the afternoon, to run simultaneously, will be Ames Laboratories presentation of "Profiles on Urinalysis" and "Telephone Communication, the Patient/Medical Assistant Relationship" presented by Margaret Pluckhan, PhD, Denver, Colorado.

At the Kenosha seminar March 4, 1977 the mini-test will again be offered in the morning followed by "Settling a Patient's Estate, the Wisconsin Medical Assistant and the Law" presented by a representative of the Wisconsin Medical Society. In the afternoon, to run simultaneously, will be Ames Laboratories presentation of "Diabetes Detection" and a program on "Communication Principles."

The seminars at both Stevens Point and Kenosha will be held at the Holiday Inns. The luncheons will include fashion shows featuring the fall/winter look and in the spring, uniforms for the best in office fashion.

This year, as in previous years, the AAMA is indebted to the State Medical Society of Wisconsin and WPS who have again provided us this printing, handling, and mailing of the program brochures. Their continued support enables us to keep our registration costs at a minimum and still offer top-notch speakers and excellent educational programs to increase our knowledge and professionalism as medical assistants.

Deadline for registrations will be twenty (20) days prior to the date of each seminar. Further information may be obtained by writing the Professional Development and Advancement Chairman Mrs Carol Norton, CMA, 7103 Pershing Blvd, Kenosha, WI 53142; or by calling (414) 694-3904. We, the Wisconsin Society of the American Association of Medical Assistants, hope to see your medical assistant at one of the above seminars.—MARILYN J TIMME, CMA ■

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Cancer treatment—art or science?

MRS SMITH CALLED the Cancer Information Service in Madison recently to request information on cancer chemotherapy. Her physician had offered her the option of two drugs for the treatment of breast cancer, and she wanted information on their side effects in order to decide which treatment she would prefer. The physician had indicated that her chances of responding to treatment would be about the same with either option, so he was leaving the final decision for her. She was concerned and needed some calm, objective information to help her make this decision.

Had the physician tried to explain the alternatives to Mrs Smith? According to recent studies,[1] much of the information given patients in a doctor's office may not be remembered. Patients often need to hear explanations or directions several times, perhaps by a nurse or other knowledgable person, in addition to the doctor. Printed material may help, because patients can study it when they are more relaxed and have time to reflect on what they have been told.

At medical meetings and tumor boards, physicians are presented with figures and statistics comparing various protocols and modes of treatment, so it is easy to lose sight of the patient. Johnny Jones may be thought of as patient No. 107 of protocol No. 6601 for treating acute leukemia. Concern may be expressed as to how long Sue Johnson has survived after amputation of a primary osteogenic sarcoma followed by treatment with adriamycin, rather than asking how she is adjusting to the amputation and what really is her quality of life.

For Mrs Smith the two drugs suggested probably will have a comparable effect; however, one drug causes more severe side effects. Mrs Smith is already having difficulty adjusting to the mastectomy—she feels she is an incomplete person and sexually unattractive to her husband. Will she be psychologically able to cope with severe gastrointestinal disturbances plus the loss of her hair? Will the possible increase in the length of her life be any more than a survival statistic? Will the quality of her life enable her to accomplish some of her desires—be a source of strength and guidance to her children, a helpmate for her husband who has just opened a new business—or will it merely be an agonizing, depressing experience for all?

A patient's personal traits often strongly influence the results of medical treatment. For example, the Morgans are very unorganized, are always late for appointments, and often fail to follow instructions for home treatment. By contrast, the Youngs never miss a yearly physical and conscientiously follow all advice. If a doctor desires to use a drug which requires the patient's cooperation to take it on specific days for six months, he knows that Mrs Morgan will probably not take the medication, whereas Mrs Young will take it faithfully. This alone may be much more important in determining the effectiveness of the treatment than the drug itself.

So the physician must know a little about Mrs Smith to help her make a wise choice—her lifestyle, her will to live, the support she will receive from family and friends, her ability and willingness to cooperate, her understanding of her disease and its treatment, and her fears and misconceptions.

Modern technology and science have progressed so rapidly that everyone has been overwhelmed by the mass of drugs, instruments, surgical procedures, medical literature, and alternative treatments available. To evaluate cancer therapy results, physicians are leaning more on technology to help them make important decisions. There has been a tendency to believe that medicine is a science, but there still is a place for art in medicine. Good cancer therapy is both an art and a science, with the well-being of the individual patient the ultimate goal.

Dr Geoffrey Falkson of the H F Verwoerd Hospital, Pretoria, South Africa, was recently appointed visiting professor to University Hospitals, Madison. He will spend at least a week each year in the United States observing those intangible concepts of patient care which cannot be expressed in words or statistics at medical meetings but which greatly influence the results of cancer therapy and the quality of life of a cancer patient.

The Wisconsin Cancer Information Service (CIS) in Madison is available to help both physicians and patients. The CIS was able to help Mrs Smith in her decision-making and relations with her physician by helping her sort out the facts, identifying gaps in her knowledge of her disease, outlining possible pros and cons, considering other possible factors before making the decision, and listing questions to ask the doctor to get more help in making that decision. Usually patients appreciate such help; it seems to help them make such a decision more easily. The counselors can often calm fears and help patients make a firm commitment to their choice. If you would like more information about how the CIS can help you and your patients, the counselors can be called toll-free at 1-800-362-8038.

—DOROTHY J BUCHANAN-DAVIDSON, PHD
Science Writer

[1]Robinson, George; Merav, Avraham: *Ann Thorac Surg* 22 (3), 1976.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

Fall Cancer Conference

The Fall Cancer Conference will be held Saturday, October 8, at University of Wisconsin Hospitals in Madison. See the Medical YELLOW PAGES in this issue for details.

Dial Access

For a catalog of the tape recordings of recent diagnostic and therapeutic information on specific neoplastic disease problems which are available to Wisconsin physicians, dentists, nurses, and students, please contact the Wisconsin Clinical Cancer Center. ■

SMS creates new Committee on Environmental Health

The Committee on Environmental Health was created by the Commission on Governmental Affairs with the approval of the State Medical Society Council in July.

The Committee was created for several reasons: first, to allow the Commission and the State Medical Society to develop informed and realistic positions on pending legislation which attempts to resolve major environmental concerns facing Wisconsin citizens; and second, to allow the State Medical Society staff representatives who deal with the Legislature to adequately respond to inquiries regarding enviromental matters from a health perspective.

Since the inception of the Physicians Alliance concept of legislative involvement, the State Medical Society's legislative representatives have received requests from legislators who wish to know the Society's position—from the standpoint of health preservation—on major environmental legislation. Government intervention at the state level in environmental matters is on the increase due to both the failure of comparable federal programs and increased delegation of federal responsibilities to the State Departments of Natural Resources or Environmental Protection.

Not only are legislative proposals subject to "environmental impact" review, but so are various state building and environmental development projects. Analyses of these items from the standpoint of water, air, land, and "noise" pollution demand at a minimum some involvement of the health profession. While the collection of data surrounding these "pollutants" is the responsibility of the State DNR, its analysis and interpretation for effect on the health and well-being of Wisconsin citizens begs for physician involvement.

The Environmental Health Committee should begin to meet and review the "boundaries" of its involvement in late 1977 and early 1978. Because environmental issues are more complex than may initially be realized, it is anticipated that the Committee "routine" may not be established much before the beginning of the legislative session in January 1979. The year 1978 should serve as a time of learning and exploration for the Committee.

Physicians who desire to serve on this Committee should possess an intense *personal* interest in ecological issues. The Committee, should it choose to deal with these issues, may be asked to respond to legislative proposals ranging from the "Indoor Clean Air Act," which attempts to regulate public smoking, to the existence of chemicals (desired or not) in our water supplies. Health factors on which legislators desire information include nuclear energy, solid waste management, and "clean" air. The range of issues is endless, the demand for input into the legislative process is without boundaries.

The current Secretary of the Wisconsin Department of Natural Re-

continued on page 32

Other Council action on August 6

Meeting in Madison Saturday, August 6, at the SMS headquarters, the Council:

- Authorized the Physicians Alliance Medical Defense Committee to support two professional liability suits with "friend of the court" briefs. In one case, an SMS member is challenging a trial court's determination that a pathologist with no clinical experience in treating fractures is competent to testify as an "expert" in a malpractice suit against an orthopedist. In the other suit, a doctor is alleging that his insurance company did not provide "good faith defense," as required by his professional liability insurance contract. The company decided, against the physician's wishes, not to appeal an adverse judgment by the trial court.
- Directed an ad hoc committee to develop plans to update, coordinate, and strengthen SMS activities in peer review, mediation, discipline, continuing education, PSROs and Health Systems Agencies (HSAs).
- Okayed a second physician opinion/attitude survey of the entire membership. The Physicians Alliance Commission started the survey this month, as a part of the continuing effort by SMS to obtain physician reaction on many current issues. This will be an aid to SMS policy and planning decisions.
- Ordered negotiations with the State Department of Health and Social Services (DHSS) to halt a plan to deny Medicaid payment or require prior authorization for some 32 diagnostic or therapeutic procedures, whose "medical necessity" is being questioned by National Blue Shield. SMS believes justification should be required, but not automatic rejection on a textbook basis. SMS will seek Peer Review Commission analysis of these procedures and the physicians who perform them.
- Urged WisPRO to collaborate with WHCRI (Wisconsin Health Care Review, Inc), under the latter's direction, in the development of peer review programs for private health insureds.
- Approved plans for the 1977 Work Week of Health for high school students, October 18 at Eau Claire Civic Center and October 19 at the Winnebago Health Institute. Theme: "Is There Life After High School?"
- Endorsed two new Communications projects under the direction of the SMS Public Information Commission: (1) a plan for improving physician-news media relations through each county medical society; and (2) a newspaper advertising campaign to tell the doctors' side of the story on issues affecting fees and rising health-care costs.
- Supported immediate revision and improvement of Wisconsin's public immunization clinic procedures, and opposed President Jimmy Carter's plan to adopt unsuccessful "swine flu" strategy to a new nationwide all-purpose immunization effort. ■

Two Wisconsin jails receive approval for accreditation

The American Medical Association's Jail Health Project has given preliminary approval for accreditation to two Wisconsin jails, Eau Claire and Milwaukee.

The Eau Claire County Jail received "full accreditation" from the AMA, meaning it has met most of the 83 standards of care established by the Project.

"Provisional accreditation" was granted the Milwaukee County Jail which met many of the standards and shows strong promise of meeting the rest.

The State Medical Society operated the AMA's program in Wisconsin which involved the development of standards for health care in jails. The procedures developed, tested, and adopted in the Wisconsin jails include: standards for health screening of new inmates, emergency and nonemergency care, chronic and convalescent care, preventive medicine, dental care, detoxification, hygiene, food services, and pharmaceuticals.

The Eau Claire and Milwaukee jails provide examples of how the health of jail inmates will be improved under the program. In Eau Claire, the jail has initiated a sick-call system, with a nurse visiting the jail three times a week to treat prisoners. That facility also is setting up an examining room with a physician scheduled to visit the jail regularly to treat patients and to administer physical examinations to those inmates who have been incarcerated for 14 days.

Milwaukee County Jail officials have formalized a complete health screening system for each entering inmate to determine if the person is suffering from any illness or injury. Every report is reviewed by a nurse and referred to a physician if necessary. Inmates have timely access to the fulltime jail nurses or to a physician.

It is hoped that these models for health-care delivery in jails can be duplicated in other Wisconsin jails and nationally. Although participation in the program is voluntary, law enforcement authorities have shown an eagerness to cooperate because of humanitarian reasons and due to an increasing number of lawsuits which have determined that the lack of medical care, among other things, represents cruel and unusual punishment in violation of the Constitution. ■

ENVIRONMENTAL HEALTH

continued from page 31

sources has already informally agreed to have either the Chairman of this Committee or one of its members serve on the Secretary's Council of Environmental Advisors. The potential for positive physician/medical input into that department is great.

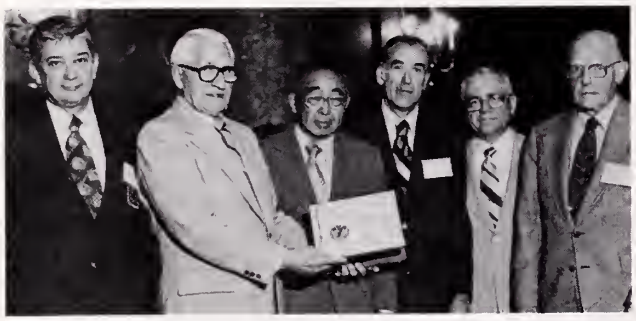
In the months of October through December 1977, the staff responsible for the Commission on Governmental Affairs will begin to compile a listing of the types of issues which the Committee might want to begin to analyze.

Any physician desiring information on this Committee or having ideas for its activities should contact either the Chairman of the Commission on Governmental Affairs, Joseph M Lubitz, MD, or the State Medical Society staff at PO Box 1109, Madison, WI 53701. (Phone: 608/257-6781, ext 115). ■

AMA National Jail Conference held in Milwaukee, August

Presentation of accreditation awards to two Wisconsin county jails (see separate story elsewhere) was made during the National Jail Conference of the American Medical Association in Milwaukee, August 21-22. Pictures of the presentation participants appear below.

Some 400 persons attended the conference which was sponsored by the National Jail Association through auspices of the AMA, in conjunction with American Correctional Association and Congress of Correction. Sheriff Larry Jacobson of Eau Claire County (Wisconsin) was a panelist on a "Report from the Field—The Impact of the AMA Jail Project." ■



MILWAUKEE JAIL HEALTH AWARD presentation participants: (L/R) Lt Joseph Little, Chief Jailor, Milwaukee County Jail; Sheriff Michael S Wolke, Milwaukee County Sheriff; Shimpei Sakaguchi, MD, President-elect, Medical Society of Milwaukee County; John C LaBissoniere, Madison, Jail Health Care Project Director, State Medical Society of Wisconsin; Jules D Levin, MD, Milwaukee, President-elect, State Medical Society of Wisconsin; and Herbert C Modlin, MD, Topeka, Kansas, Chairman, AMA National Advisory Committee to Improve Medical Care and Health Services in Correctional Institutions.

EAU CLAIRE JAIL HEALTH AWARD presentation participants: (L/R) Richard S Ostenso, MD, Eau Claire, President, Eau Claire-Dunn-Pepin County Medical Society; Jules D Levin, MD, Milwaukee, President-elect, State Medical Society of Wisconsin; Sheriff Larry Jacobson, Eau Claire County; John C LaBissoniere, Madison, Jail Health Care Project Director, State Medical Society of Wisconsin; and Herbert C Modlin, MD, Topeka, Kansas, Chairman, AMA National Advisory Committee to Improve Medical Care and Health Services in Correctional Institutions.

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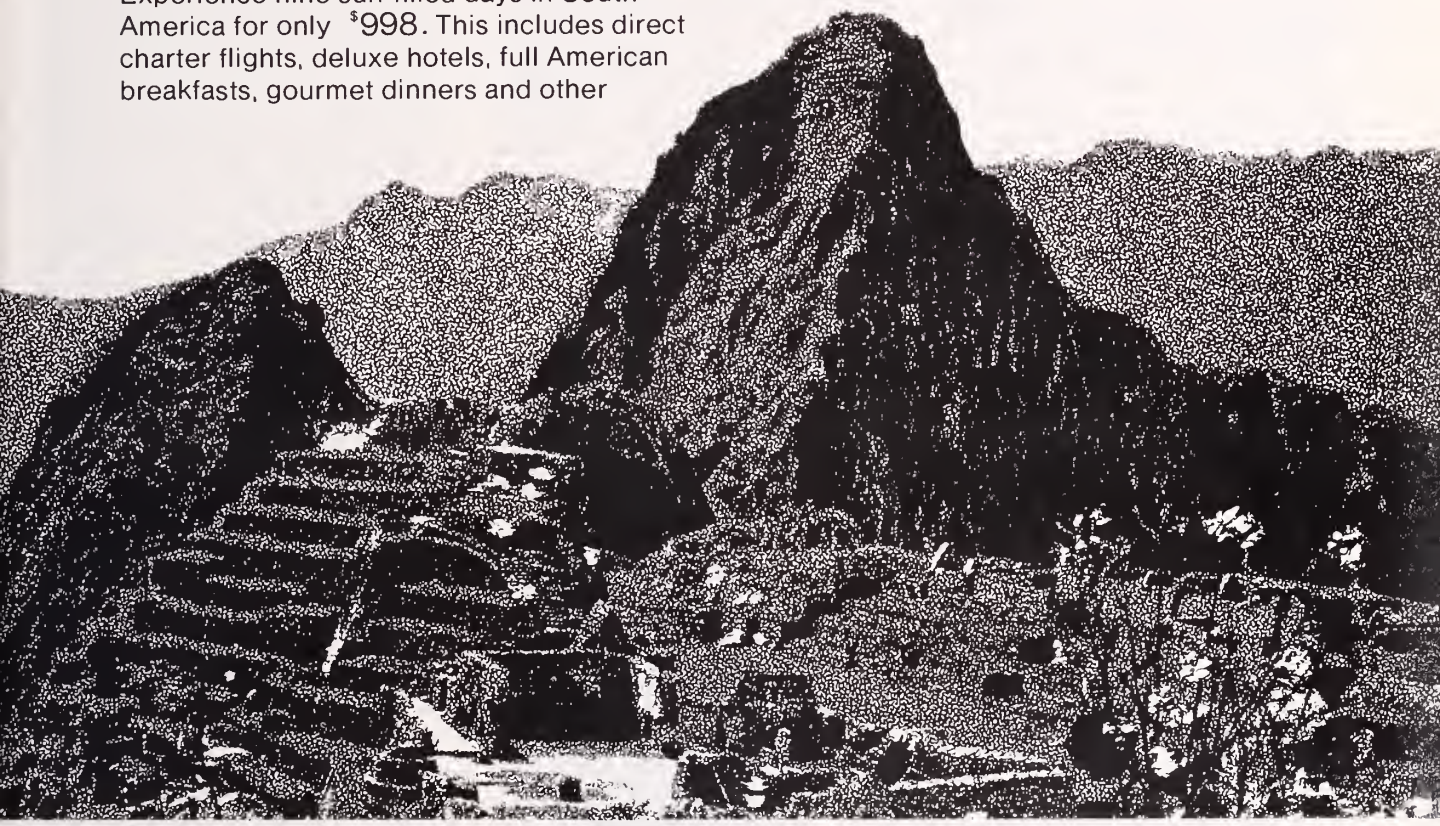

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Medical Defense Committee to issue briefs

The SMS Council has instructed the Physicians Alliance Medical Defense Committee (MDC) to support two professional liability suits with "friend of the court" briefs.

The Committee and a Madison law firm are preparing one brief in support of a physician's charge that his insurance company failed to appeal an adverse malpractice decision by a lower court and therefore didn't provide a "good faith defense" as provided in the professional liability contract.

The case is expected to be scheduled for hearing sometime in November 1977.

Whether a pathologist with no clinical experience in treating fractures is competent to testify as an "expert" in a malpractice suit against an orthopedist is the issue involved in another brief which the MDC will present to the Wisconsin Supreme Court.

SMS will prepare a brief in support of specialists testifying on proper treatment in the area in which they have training, expertise, and experience.

Because of the heavy caseload in the Supreme Court, the case is not expected to be heard for 12 to 18 months.

In the September legislative session, the Society also will introduce a bill prepared by the Physicians Alliance Ad Hoc Committee on Professional Liability which established criteria for expert medical witness testimony. ■

1977 Work Week of Health to help high school seniors

"Before You Solo, Pack Your Parachute" is the theme for the 15th Annual Wisconsin Work Week of Health, sponsored by the State Medical Society of Wisconsin and its Auxiliary.

The teen institutes are scheduled for Tuesday, October 18, at the Eau Claire Civic Center and on Wednesday, October 19, at the Winnebago Mental Health Institute. The program is planned for high school seniors as a preparation for life after high school.

New this year—attendance each day will be limited to 150 students; each school is asked to send one or two seniors as delegates to the conference. The students will receive training to set up similar workshops in their local schools.

Darold Treffert, MD, will be the keynote speaker with "Only You Can Pack Your Parachute." He and other members of his staff at the Winnebago Mental Health Institute will lead workshops. The morning session, "Coping With Every Day Hassles," will deal with problem areas students do and will face—alcoholism, drugs, sex, decision-making. The second workshop, "A Bagful of Good Feelings," will deal with helping teenagers understand themselves and others. A movie will provide information on alternatives and values.

This approach is being tried this year so that local schools will have increased exposure. More students can be involved at the local level and there can be continued followup on the information received at Work Week of Health, rather than a one-time program.

Auxiliary members can be instrumental in encouraging local school participation, possibly providing transportation, and perhaps helping the delegates set up their local mini-Work Week institute. ■

SMS Variable Annuity

. . . Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.335 as of July 29, 1977. ■

Membership recruitment campaign underway

In an effort to attract more physicians to the SMS membership roles, the Communications Department has undertaken a membership recruitment campaign among current nonmembers. This effort is at the direction of the Commission on Public Information.

The names of those physicians who are not members of SMS were obtained from the American Medical Association. A membership recruitment kit is being prepared for each of those physicians; the kit includes a brochure explaining SMS-county society programs, a brochure detailing AMA efforts, a letter from SMS President Roy B Larsen, MD, plus a membership application form.

The kits will not be mailed to potential members from the SMS Madison headquarters. Instead, the kits, ready for mailing, will be sent to each county society, which then will determine which physicians will actually receive an invitation to join since the county societies are the initial entry point for those seeking to join the organized medicine team.

Doctor Larsen further explains the campaign in his President's Page elsewhere in this issue. ■

Family Physician seminars scheduled for Green Bay

The State Medical Society's Commission on Continuing Medical Education will hold three one-day seminars for family physicians at two Green Bay hospitals this fall.

The dates and locations of the seminars are:

Wednesday, September 21, St Vincent Hospital, Green Bay
Wednesday, October 19, Bellin Memorial Hospital, Green Bay
Wednesday, November 16, St. Vincent Hospital, Green Bay

Seminar topics will include: "Computerized Axial Tomography," "Obstetrical Uses of Tonography and Ultrasound Diagnostics," "Clinical Enzymes," "Chest Pain and Management of Cardiac Arrhythmias," "Obesity and Nutrition," and "Organic Brain Syndrome." Physicians attending the entire seminar series will receive 12 hours of Category I CME credit. The fee for the entire series is $35 for SMS members and $75 for nonmembers. For more information contact CME Coordinator Bill Wendle at SMS offices, 330 East Lakeside Street, Madison, WI 53701. ■

House of Delegates Nominating Committee to meet Sept. 25

The House of Delegates Nominating Committee will meet Sunday, September 25 at 10 a.m. at the SMS Madison headquarters. County medical societies are urged to nominate members for the offices of president-elect and vice-speaker for 1978-79 and AMA delegates for calendar years 1979-1980.

Jules D Levin, MD, Milwaukee, is the current president-elect, and Duane W Taebel, MD, LaCrosse is vice-speaker.

Current AMA delegates include: John E Dettmann, MD, Green Bay; George E Collentine Jr, MD, Milwaukee; and DeLore Williams, MD, West Allis.

Alternate AMA delegates include George A Behnke, MD, Kaukauna; Harold J Kief, MD, Fond du Lac; and Patricia J Stuff, MD, Bonduel.

County medical societies should send nomination information to the Nominating Committee in care of SMS in Madison as soon as possible. In addition, all candidates are encouraged to present themselves at the September meeting. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of July 15, 1977

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

CHIPPEWA

Sangalang, Romeo B, Rte 5, Chippewa Falls 54729 (1942, Regular, General Surgery/General Practice)
Thirakomen, Khamnung, 133 W Central St, Chippewa Falls 54729 (1944, Regular, Internal Medicine/Nephrology)

DANE

Kosseff, Andrew L, 1313 Fish Hatchery Rd, Madison 53715 (1947, Regular, Internal Medicine)
Rudat, Karl A, 1313 Fish Hatchery Rd, Madison 53715 (1947, Regular, Obstetrics and Gynecology)

MILWAUKEE

Chatterjee, Ashok K, 9004 W Lincoln Ave, Milwaukee 53227 (1938, Regular, Obstetrics and Gynecology)

RACINE

Sooknandan, Ghonsham, 809 16th St, Racine 53403 (1927, Regular, Clinical Pathology/Family Practice)
Wilz, Donald R, 5625 Washington Ave, Racine 53406 (1946, Regular, Internal Medicine/Nephrology)

WAUKESHA

Hansen, Peter T, 18625 Lechateau Dr, Brookfield 53005 (1940, Regular, Anesthesiology, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DANE

Bodensteiner, C Gary, Madison, to 900 Illinois Ave, Stevens Point 54481
Echeverry, Alejandro, Middleton, to 4302 Nicklaus, Corpus Christi, TX 78413
Hadley, Richard N, San Diego, CA, to 9626 Toledo Circle, Bloomington, MN 55437
Kennan, Alfred L, Madison, to 525 Bayside Dr, Fort Myers, FL 33901
Kirkham, Wayne R, Madison, to 4318 Shady Bend, Dallas, TX 75234
Souther, Sherman G, Madison, to 2100 Forest Ave, San Jose, CA 95128

DODGE

Roberts, Rob R, Mosinee, to 2821 South Ave, LaCrosse 54601

LANGLADE

Chatterjee, A N, Antigo, to 223 Ann St, Kaukauna 54130

MANITOWOC

Miller, Herbert P, Jr, Manitowoc, to 900 Illinois Ave, Stevens Point 54481

MILWAUKEE

Hettwer, Rose A Kriz, Shorewood, to 10 Ridge Rd, Rumson, NJ 07760
Kusterman, John A, Milwaukee, to PO Box 2251, Harrisburg, PA 17105
Marks, Norman S, Milwaukee, to 139 Knox Dr, West LaFayette, IN 47906
Morton, Silvanius A, Beirut, Lebanon, to 4025 - 2G Calle, Sonora Este, Laguna Hills, CA 92653
Terry, Daniel W, Jr, Manhattan, KS, to 8339 Brentmoor, Wichita, KS 67206
Tsao, Ming-Jyi, Milwaukee, to PO Box 6000, Ocala, FL 32670
Verdone, Anthony J, Milwaukee, to 1600 N Ocean Blvd, Tiffany Gardens West, Pompano Beach, FL 33062

ONEIDA-VILAS

Pfeffer, Robert A, Rhinelander, to 118 East Grand Ave, Port Washington 53074

OUTAGAMIE

Keane, Keith M, Appleton, to 310 North Wilmot Rd, Tucson, AZ 85732

PORTAGE

Kennedy, John T, Stevens Point, to 64 Bronson Medical, Kalamazoo, MI 49006

RACINE

Hirsh, S Jay, Racine, to 6061 Maple Wood Dr, Springfield, PA 19064
Ivsin, Rostislav, Saukville, to 3815 Erie St, Racine 53402

SAUK

Savdie, Solomon, Prairie du Sac, to PO Box 506, Carrollton, GA 30117

SHEBOYGAN

Holmstrom, Robert D, Sheboygan, to 31 Royal Palm Blvd, Vero Beach, FL 32960

WAUKESHA

Correa-Paz, F, Waukesha, to 6114 Elizabethan Dr, Nashville, TN 37205

DEATHS

Andrews, Walter C, Polk County, Apr 8, 1977
Albino, John M, Racine County, June 16, 1977 ■

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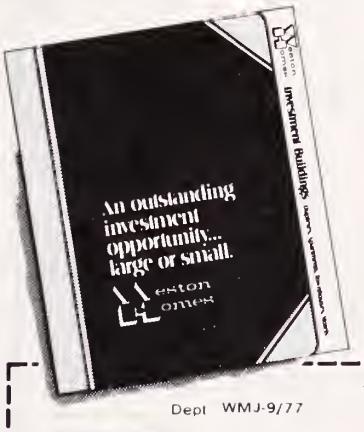

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OBITUARIES

◈County, State, AMA Members

◈ **Walter C Andrews, MD,** 78, Phoenix, Ariz, died Apr 8, 1977 in Phoenix. Born Apr 5, 1899 in DeSmet, South Dakota, Doctor Andrews graduated from the University of Minnesota Medical School in 1923. He practiced general medicine in Frederic from 1928 until he retired in 1965. He was a member of the "50 Year Club" of the State Medical Society of Wisconsin. Surviving is his widow, Edith.

John Thomas Murphy, MD, 62, Mitchell, SD, died May 18, 1977 in Mitchell. Born Jan 11, 1915 in Green Bay, Doctor Murphy graduated from Marquette University School of Medicine in 1940 and was a radiologist in Sturgeon Bay before moving to Mitchell. Surviving are his widow; and two daughters, Dr Kathleen Murphy Cody, San Antonio, Tex, and Mrs Sheila Murphy Hill of Minneapolis, Minn.

◈ **John M Albino, MD,** 79, Racine, died June 16, 1977 in Racine. Born Sept 3, 1897 in North McGregor, Iowa, Doctor Albino graduated from Marquette University School of Medicine in 1924. He served in the United States Army during World War I and in 1924 he started his practice of general medicine in Racine. He retired in 1962. Doctor Albino was a member of the "50 Year Club" of the State Medical Society of Wisconsin. Surviving are his widow, Dorothy; and two sons, Arthur and Jea of Milwaukee.

◈ **Richard J Dietz, MD,** 71, Waterford, died July 21, 1977 in Burlington. Born Apr 4, 1906 in Milwaukee, Doctor Dietz graduated from Marquette University School of Medicine in 1934, and had practiced medicine in the Waterford area for over 40 years. Surviving are his widow, Evelyn; and three sons, Richard, Gregory, and David.

◈ **Earl F Weir, MD,** 72, Nashotah, died July 28, 1977 in Nashotah. Born Jan 21, 1905 in Waupun, Doctor Weir graduated from the University of Wisconsin Medical School in 1933. Doctor Weir developed the mobile post-anesthesia recovery unit in the early 1950s and was honored by the National Library of Medicine, Bethesda, Md, because of his contributions to medical science. Doctor Weir was chief of anesthesiology and director of operating rooms at Baylor University Medical Center, Dallas, Tex, for a number of years. He also practiced medicine in Oconomowoc before joining the staff of the National Joint Commission on Accreditation of Hospitals. Surviving is his son, James of Oconomowoc.

Casper L Berner, MD, 60, Milwaukee, died July 31, 1977 in Milwaukee. Born Sept 11, 1916 in Milwaukee, Doctor Berne graduated from Marquette University School of Medicine in 1942. He served in the United States Army from 1943-1946. Surviving are his widow, Eileen; three sons, Michael, Paul, and Mark; and three daughters, Mary, Jeanne and Julie. ■

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COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

June 4, 1977—Madison

SPECIAL ORDERS: Prior to formal meetings of the CES Foundation board of trustees and the Council, the Foundation's John H and William J Houghton Award was presented to Ms Diana L Kruse, University of Wisconsin Medical Student, by Patricia J Stuff, MD.

The Society's Distinguished Service Award was presented on behalf of the Council to Thomas A Leonard, MD, by a fellow member of the Maternal Mortality Study Committee, Richard C Brown, MD.

1. Call to Order and Roll Call

The Council was called to order by Chairman Haskins at 1:45 pm on Saturday, June 4, 1977, at the State Medical Society, following the annual meeting of the CES Foundation board of trustees.

Voting members present: Chairman Haskins; Vice-chairman Edwards; Doctors Boulanger, Foley, Nielsen, Bruhn, Steffen, Mullooly, Eisenberg, Crowley, Waterhouse, Kief, Lewis, Peters, Flaherty, Smejkal, Barrette, and Doyle; President-elect Levin, Speaker Motzel, and Vice-speaker Taebel.

Present for CES Foundation meeting: Doctors Cooney, Pomainville, John R Larsen, Judge Kent C Houck.

Others: Doctors Nordby, Derus, Collentine, Williams, Scott, Stuff, Viste, Lubitz, Hoeper, Kempthorne, Nereim; Dr and Mrs Charles R Lyons; Messrs Maroney, Simms, LaBissoniere, Wendle, Brozek, Opin, Robert B Murphy, Donald L Bailey; Mmes Reinhardt, Bartel, and Meyer.

2. Minutes of April 13 and April 16, 1977

On motion of Doctors Nielsen-Waterhouse, carried, these minutes were accepted as distributed.

3. Oath of Office

The oath of office was taken by newly elected councilors: Elizabeth Steffen, MD, Racine; Carl Eisenberg, MD, Milwaukee; and Antoine Barrette, MD, Peshtigo.

4. Election of Editorial Director, *Wisconsin Medical Journal*

By motion made, seconded and carried, Wayne Boulanger, MD, was nominated and elected as Editorial Director to succeed Doctor Headlee who resigned.

5. Report of Nominating Committee

By various motions made, seconded and carried, the Council elected the following to vacancies on commissions and committees, as proposed by the Nominating Committee:

RAYMOND ZASTROW, MD, Milwaukee, three-year term on Commission on Governmental Affairs (1980)

JOHN WEAR, JR, MD, Madison, unexpired term (1979) on Commission on Mediation and Professional Ethics

RICHARD LOGAN, MD, Madison, three-year term on Commission on Peer Review (1980)

KENNETH R PETERS, MD, Menomonee Falls, unexpired term on Committee on Occupational Health (1978)

EDWARD D MEYER, MD, Oshkosh, three-year term on Committee on Mental Health (1980)

Doctor Nereim, vice-chairman of the Committee on Nervous and Mental Diseases, reported on its May 28 meeting when it agreed the committee should continue in existence with a minimum of three meetings a year directed toward administrative, legislative, and therapeutic aspects of the mental health field in Wisconsin, and recommended a name change to Committee on Mental Health.

On motion of Doctors Crowley-Motzel, carried, these recommendations were accepted.

Chairmanship of Nominating Committee: On motion of Doctor Motzel, seconded and carried, the Chairman of the Council was designated to act as Chairman of the Nominating Committee of the Council.

No action was taken at this time to specify the chairmanship of the Auxiliary Advisory Committee.

6. Report of Executive Committee—Minutes of May 13 Meeting

A. Recommendations re WPSIC

(1) On motion of Doctors Smejkal-Mullooly, carried, the Council approved the recommendation that the terms of the initial WPSIC board members, some of which expire in 1977, each be extended for one year.

(2) Transfer Agreement and Use of Tradenames

On motion of Doctors Edwards-Boulanger, carried, the Council approved the entire Transfer Agreement, which does refer to policies regarding the use of tradenames, and disapproved the use by WPSIC of the phrase "Blue Shield Plan of The State Medical Society of Wisconsin," or any others recited or inferred in the second sentence of that part of the Transfer Agreement (item C, paragraph 4), after the initial notice to subscribers announcing the separate incorporation.

The Council also received a memorandum from Secretary Thayer dated June 2, 1977, re "Progress on Transfer Agreement and Related Matters." It was moved, seconded and carried, that this memorandum be adopted as Council policy. Copy attached to original minutes.

(3) On motion of Doctors Lewis-Eisenberg, carried, the Council approved the recommendation that the WPSIC board nominate the consulting CPA firm to conduct the annual audit of WPSIC, subject to ratification of the Council as the corporate membership.

(4) WPSIC Board of Directors

Council members were reminded that nine additional public members (including a reasonable proportion of females and minority members) must be added to the WPSIC board of directors by January 1, 1978, and that any suggestions for nominees should be forwarded to staff or the Nominating Committee.

B. Council Meeting Schedule

On motion of Doctors Eisenberg-Edwards, carried, the Council approved the recommendations of the Executive Committee that the October Council meeting be changed from the 8th to the 15th, and that the invitation of President Larsen to hold the Council "retreat" at Employers Insurance in Wausau on September 16-17 be accepted.

C. May 13 Executive Committee Minutes

On motion of Doctors Kief-Edwards, carried, the Council approved in their entirety the recommendations incorporated in the Executive Committee minutes of May 13, 1977, copy attached to original minutes.

7. Report of Finance Committee—Doctor Edwards

The committee met in the morning and first reviewed and accepted the complete set of audit reports for 1976 on the Society and related divisions and subsidiaries. The April 30, 1977, report of budget and related expenses was reviewed in depth. Legal consultation continues to be overexpended due to professional liability and Medicaid fee freeze lawsuit charges, but in total the budget is underexpended by $19,000. There was considerable discussion of legal costs and coordination of assignments to legal firms. The consensus of the committee was that staff should continue to handle as many matters as possible, with the realization that some mistakes may be made, and that use of outside legal counsel be kept at a minimum, only for more difficult and technical matters.

The committee also reviewed a report of income through May 25 which indicated total income of $1,089,000 against a total 1977 budget of $1,225,000. This is $53,000 ahead of last year's pace. At this point it appears that income will be very close to the budgeted amount by year end. The report also reveals 130 more members have paid dues and 28 more new members have been elected in the first five months of this year as compared to 1976.

Copies of the status of dues payments by county society were available at the meeting with the suggestion that councilors review their respective counties; staff can provide names of unpaid members if desired.

The last item of discussion was on SMS membership services. There has been more investigation of this possibility, and while the committee feels there may be some potential for service to members in the areas previously discussed, most are not realistic as a State Society endeavor. Staff has been requested to further investigate group insurance, educational and data gathering aspects as their first effort in this general area, and report back at a future meeting.

On motion of Doctors Bruhn-Foley, carried, the report of the Finance Committee was accepted.

8. Physicians Alliance Commission—Doctor Viste

A. Title 19 Developments

Materials distributed with the agenda and at the meeting were discussed at some length: Title 19 certification/decertification rules, provider contract, and the Court's findings and judgment on the Medicaid fee freeze.

Mr Simms indicated that a decision from Mr Carballo as to whether the State will appeal the judgment in the lawsuit, which declared the freeze illegal, was being awaited. Doctor Andreano has recommended that it not be appealed.

Doctor Frank and Mr Thayer have been working on the Wisconsin Medical Assistance Provider Contract (latest draft distributed) with DHSS. The terms of reimbursement have not yet been completed, and there is a July 1 deadline.

A mechanism must be established to inform the membership that just because the lawsuit has been won, the fight is not yet over; suggest that SMS members may not wish to sign the Title 19 provider contract unless a satisfactory agreement for reimbursement can be worked out. In the lawsuit, reimbursement at Title 18 levels was requested.

On motion of Doctors Waterhouse-Mullooly, carried, the Council requested that the membership be notified about the current provider agreement form and that they will be further advised of the Society's recommendations. With the basis of this knowledge, it will be the decision of each individual physician as to whether he wishes to sign the agreement at this time.

B. Professional Liability

The Council was informed that the problem is still current. It was suggested the members write personal letters to legislators in an effort to pass SMS-supported bills. This could help to resolve some remaining problems.

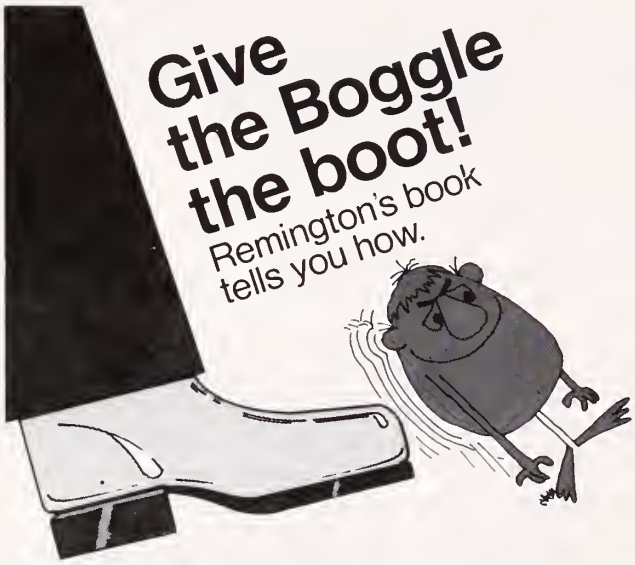
C. Auxiliary Representative to Commission

The PAC recommendation to the Council that the Auxiliary representative to the Commission become a full-fledged voting member is to be referred to the Executive Committee of the Council.

D. Remarks by Chairman

Doctor Viste indicated concern as to how best to counter criticisms relative to "cleaning our own house"—the disabled, the impaired physician—with the resultant fear of a lawsuit by physicians doing review if anything is done about it. Staff was requested to investigate how other states are dealing with such problems.

On motion of Doctors Smejkal-Eisenberg, carried, the report of the Physicians Alliance Commission was accepted.



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9. Governmental Affairs Commission—Doctor Lubitz

A. Legislative Update

The Council received a current report on the status of health-related legislation which the Society is following. Doctor Lubitz emphasized the urgency of defeat of bill AB 784 eliminating existing examining boards as sole regulators of professions, and creating an occupational standards board, and requested that each member write his legislator in opposition to this bill.

B. Primary Care Physicians Survey

Doctor Peters had reported a request of the primary health-care subcommittee of the Health Policy Council that the Society support a survey to obtain information on primary care physicians as to office practice locations, hospitals in which they practice, and age.

It was noted that the organizational structure for conducting such a survey by HSA districts had already been approved on recommendation of the Commission on Health Facilities and Services.

C. Committee on Environmental Health

On motion of Doctor Smejkal, seconded and carried, the Council authorized the GAC to establish a Committee on Environmental Health to examine legislation concerning major environmental measures for their impact on the health of Wisconsin citizens.

D. Auxiliary Representative

The recommendation of the GAC that the Auxiliary representative become a full-fledged voting member was deferred.

10. HR 2222

The AMA Board of Trustees has publicly supported HR 2222 in Congress. This proposal would amend the National Labor Relations Act to include interns, residents, and other housestaff physicians as "professional employees" for purposes of organizing and collective bargaining. The Medical Society of Milwaukee County supports the 1976 ruling of the National Labor Relations Board to the effect that interns and residents are students at the graduate level rather than employees, opposes the AMA Board of Trustees' position, and requested the Council to consider adoption of a similar position on the issue.

The Committee on Federal Legislation has this bill under advisement and will hold a meeting on June 8, to which representatives of the two medical schools and residents are invited to participate. Action taken at this meeting will be provided to the Council and the Wisconsin AMA Delegation prior to the June AMA meeting in San Francisco.

11. Confirmation of Specialty Section Representatives on Governmental Affairs Commission

Specialty section representatives have voting privileges when present at GAC meetings, and their annual appointments are subject to Council approval. On motion of Doctors Eisenberg-Kief, carried, the following reported specialty section representatives for 1977-78 were accepted by the Council:

Michael P Mehr, MD, Marshfield, Internal Medicine
Edwin C Welsh, MD, Wauwatosa, Physical Medicine & Rehabilitation
John U Peters, MD, Fond du Lac, Family Practice
P Richard Sholl, MD, Janesville, Surgery
Raul Waters, MD, Madison, Urology
John Hamacher, MD, Madison, Plastic Surgery
Marvin Nelson, MD, Racine, Orthopedics
Elmer E Johnson, MD, Madison, Ophthalmology

12. Commission on Peer Review—Doctor Hoeper, vice-chairman

A. Recommendation that a hospital medical staff be audited as to pattern of practice

On motion of Doctors Foley-Mullooly, carried, the Council approved the recommendation that a hospital medical staff be audited as to practice pattern by the Commission on Peer Review and that the findings be relayed to the JCAH in an effort to correct any current deficiencies found.

This motion was amended by Doctor Eisenberg, seconded and carried, that since the charge of the Commission on Peer Review is education, it might be better to pass any recommendations on to the Commission on Public and Professional Affairs, which Commission could determine whether these recommendations should be referred to the JCAH, Medical Examining Board, or Division of Health.

The above two motions were reconsidered and amended: On motion of Doctors Levin-Edwards, carried, it was agreed to refer the professional recommendations (physician aspect) to the Commission on Public and Professional Affairs and the hospital recommendations to the JCAH.

Mr Murphy, legal counsel, indicated that the professional aspect as contained in the above motion should be referred promptly to the Commission on Public and Professional Affairs and that the Council take action without delay, even if a special meeting is required. He was not concerned with a lawsuit as the statutes protect committees in their work.

On motion of Doctors Crowley-Foley, carried, the Commission on Public and Professional Affairs is to determine if recommendations are to be made to the JCAH, Medical Examining Board, or Division of Health.

B. Statement on "Amphetamine Abuse in Wisconsin"

On motion of Doctors Lewis-Edwards, carried, the Council accepted a position statement on amphetamines developed by members of the Commission on Peer Review and requested its publication in the *Wisconsin Medical Journal*.

[Note: The statement as adopted appears on page 47 of the June 1977 blue book issue of the Journal.]

13. Commission on Public and Professional Affairs; Name Change and Other Recommendations—Doctor Kempthorne

Doctor Kempthorne reported recommendations to the Council from the May 25 meeting of the Commission relating to:

A. Name change to "Commission on Mediation and Professional Ethics"
B. Expanded identity to the membership and the public
C. Impaired physician program
D. Jurisdiction

On motion of Doctors Doyle-Waterhouse, carried, all of the recommendations were approved as presented, copy attached to original minutes.

14. Resolutions to AMA House of Delegates Meetings

On motion of Doctors Peters-Lewis, carried, it was requested that hereafter time be allowed on Council agendas for AMA delegates prior to House of Delegates meetings.

15. William J Egan, MD

It was moved, seconded and carried that the Council take cognizance of the passing of Doctor Egan, past president and past member of the Council, and that a suitable statement be sent to his widow.

16. Councilor Assignments

Chairman Haskins asked that the following councilors serve in a liaison capacity with commissions of the Society:

Editorial Board, WMJ—Doctor Boulanger
Continuing Medical Education—Doctor Steffen
Governmental Affairs—Doctor Peters
Health Facilities and Services—Doctor Eisenberg

MEDIATION AND PROFESSIONAL ETHICS—Doctor Barrette
PEER REVIEW—Doctor Kief
PUBLIC INFORMATION—Doctor Bruhn

In addition, the Council approved the appointment of Jan Erlandson, MD, Monroe Clinic, as an additional advisor to the Wisconsin Medical Assistants Association.

17. Proposed Examination of MD Tax Returns

By memorandum distributed at the meeting, the Secretary informed the Council that the Society had recently been informed of executive action taken in March by the Senate Human Services Committee authorizing a UW student by the name of Nestor Dominguez to examine all Wisconsin physicians' income tax returns for a research project to "formulate a Micro-Simulation Model of physician distribution patterns in Wisconsin, utilizing statistical techniques to determine the relative strengths of social, economic, and professional factors in determining physician location." Names or addresses are not to be related to income data.

On motion of Doctors Smejkal-Boulanger, carried, the Council accepted the recommendations that the Society:

A. Contact Senator Thompson personally to express concern and discuss the appropriateness of the authorization to a person who appears to be a totally unknown quantity or quality.
B. Contact Lt Governor Schreiber to express concern.
C. Have some direct input to the study, if it is to continue, so that it is at least sound and safely conducted.
D. Have absolute assurance of full disclosure of methods, working efforts and results.
E. Inform SMS members that the examination is taking place.

18. Referrals from House of Delegates to Council

Consideration of items referred to the Council by the House of Delegates in April was deferred until the next meeting.

19. Adjournment

The meeting adjourned at 4:35 pm.

H B MARONEY
Assistant Secretary

Approved August 6, 1977
PAUL S HASKINS, MD
Chairman

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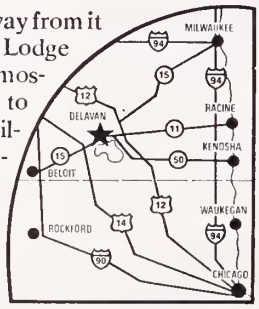

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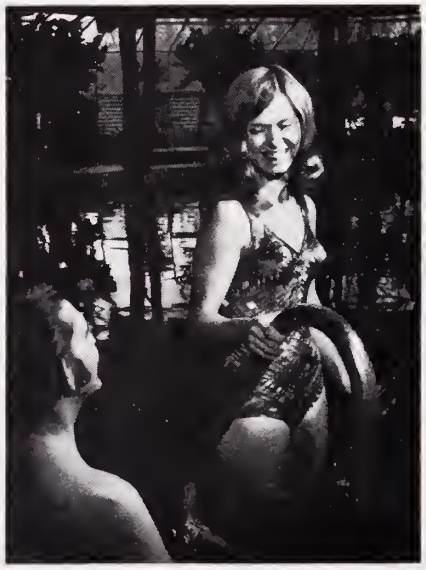

NEWS HIGHLIGHTS

New Life Perinatal Project

. . . became operational in July at the Gundersen Clinic-LaCrosse Lutheran Hospital Medical Center in LaCrosse. The Project's goals are to decrease maternal, fetal and newborn morbidity and mortality. In essence it will seek to preserve the lives and health of high-risk mothers and their infants before, during, and after birth.

The "New Life Perinatal Project" is funded by the State of Wisconsin, Division of Health, Maternal and Child Health Program. The Project was approved by Ralph L Andreano, PhD, administrator of the State Division of Health, Department of Health and Social Services.

The Project will coordinate an array of specialized expertise already available at the Gundersen Clinic-LaCrosse Lutheran Hospital Medical Center. According to Dr Edward B Miner* of the Adolf Gundersen Medical Foundation, "high-risk maternal and pediatric patients will benefit from services provided by a 'core' team composed of physicians, nurse clinicians, social workers, and nutritionists." This Core Perinatal Team is responsible for ensuring quality control of care provided to high-risk patients while maximizing efficiency of care and cost containment.

Doctor Miner stated "this complex and comprehensive project will offer its services to all high-risk patients in a service area which includes 14 counties in Western Wisconsin and adjacent counties in Minnesota and Iowa." It will be administered by a Project Director to be named in the near future.

UW Family Medicine

. . . department has added two physicians to the Department of Family Medicine and Practice. James Warrick, MD, who recently was the project physician for the trans-Alaska pipeline, is now assistant director of the department's clinic based at St Marys Hospital Medical Center, Madison. G Thomas Pfaehler, MD was named coordinator of psychiatric training for the department's 72 residents. Both physicians are University of Wisconsin Medical School graduates. Doctor Warrick practiced family medicine in California for 23 years before joining the trans-Alaska pipeline as project physician, and Doctor Pfaehler, who has been on the UW Medical School faculty since 1967, also has been in private practice since 1972.

The Marshfield Clinic

. . . recently added five new physicians, two ear, nose and throat specialists, a cardiologist, neurologist and a general internist, to its medical staff. Joining the ENT department are Dr Dhavalkirti S Dhru, a graduate of the Medical College, Baroda, India, and Dr M Hisham Tarabishi, a graduate of Alexandria Medical School in Egypt.

Doctor Dhru finished a residency at Queens University and Kingston General Hospital in Kingston, Ontario, Canada. Doctor Tarabishi was formerly chief resident of the Department of Otolaryngology at the University of Utah in Salt Lake City.

The new cardiologist is Dr Linley E Watson who graduated from the University of Kansas Medical School and was director of the cardiovascular laboratory at Harry S Truman Memorial VA Hospital in Columbia, Mo.

Dr Robert W Page joined the neurology department after finishing a residency at University Hospitals, Cleveland, Ohio. He graduated from Temple University School of Medicine in Philadelphia, Pa.

Dr Michael J Kryda was a staff physician and instructor in medicine at Camp Pendleton, Calif, prior to joining the Clinic staff. He is a graduate of the University of Illinois Medical School in Chicago.

Milwaukee Psychiatric Hospital

. . . Wauwatosa, is presenting a series of conferences on the "Medical and Social Aspects of Mental Illness." They began September 7 and will continue through June 14, 1978, according to an announcement by Morton Josephson, MD,* clinical director, and Gerald E Schley, executive director. The conferences are conducted for physicians and mental health-care workers, who can earn one hour of American Medical Association Category I credit.

The conferences are held in the Dewey Center lecture hall on the Hospital grounds, 1220 Dewey Ave. Those interested in attending the lectures are urged to call (414/258-2600) or write the Hospital for schedule information. ■

PHYSICIAN BRIEFS

Donald D Johnson, MD

. . . Stevens Point, has joined the medical department at the World Headquarters of Sentry Insurance as associate medical director. Before joining Sentry, Doctor Johnson was director of the Student Health Service at the University of Wisconsin-Stevens Point for nine years. He graduated from Baylor Medical School, Houston, Tex, and completed his internship at University Hospital, Ann Arbor, Mich, and Mercy Hospital, Benton Harbor, Mich.

Steven Blatnik, MD
Thomas R Gruszynski, MD*

. . . Menomonee Falls, recently became associated with Medical Associates Clinic of Menomonee Falls. Doctor Blatnik has been chief orthopedic resident at the University of South Florida in Tampa. He is a 1971 graduate from the University of Wisconsin Medical School, Madison, and completed his residency at the University of Oklahoma in Oklahoma City, Oklahoma. Doctor Gruszynski graduated from the Indiana University Medical School in 1970, and is a member of the Ob-Gyn faculty at the Medical College of Wisconsin.

James Ansfield, MD

. . . recently became a member of the medical staff of Ozaukee Medical Center, Thiensville. An internist, with a specialty in gastroenterology, Doctor Ansfield graduated from Marquette Medical School in Milwaukee, and took his residency at the UCLA Medical Center and Wadsworth Hospital in Los Angeles. Prior to joining the Ozaukee Medical Center, Doctor Ansfield spent two years with the United States Air Force and with the Denver Clinic, Denver, Colo.

Egbert Kamstra, MD*

. . . formerly a psychiatrist with The Monroe Clinic, recently moved to Stevens Point. Doctor Kamstra joined The Monroe Clinic in 1964 and was a member of the medical staff of St Clare Hospital. In Stevens Point, Doctor Kamstra will be doing some counseling at the University of Wisconsin-Stevens Point and teaching at the University. He also will be associated with St Michael's Hospital.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

John A Austin, MD*

. . . recently opened his medical practice in internal medicine in Janesville. A 1971 graduate of the University of Illinois College of Medicine, Doctor Austin served his internship in hospitals in Chicago, and joined the United States Air Force where he was chief of clinical services in Syracuse, NY. He completed his internal medicine residency at Hines Veterans Administration Hospital. Doctor Austin is a member of the American College of Physicians and is on the medical staff of Mercy Hospital, Janesville, and Community Memorial Hospital in Edgerton.

John P Gauder, MD

. . . Stevens Point, recently became associated with the Rice Clinic, SC, in the Department of Internal Medicine. Doctor Gauder received his medical degree from the University of Indiana Medical School in 1973 and completed his internship at Indiana University Medical Center Hospital, Indianapolis. Doctor Gauder's residency was taken at the University of Nebraska Medical Center in Omaha.

Barton Blum, MD

. . . Waupaca, has joined the medical staff at Riverside Community Memorial Hospital and Waupaca Family Medicine Associates. A surgeon, Doctor Blum served in the United States Air Force for two years after completing his medical degree at Loyola University Medical School in Chicago. He also spent five years as a surgeon at Hennepin County General Hospital, Minneapolis, Minn.

George B Breadon, MD

. . . Dublin, Ireland, recently became associated with The Monroe Clinic in the Department of Ear, Nose and Throat. Doctor Breadon, former chief resident in Otorhinolaryngology at Mayo Clinic, Rochester, completed five years in residency at the Clinic. A 1968 graduate of the National University of Ireland, he had a year of internship in Dublin and another year at the Greater Baltimore Medical Center.

Doctor Breadon recently won an award from the American Academy of Facial, Plastic and Reconstructive Surgery.

John DeGiovanni, MD
John Koch, MD*

. . . have joined the medical staff of the Prairie Clinic, Prairie du Sac. Doctor DeGiovanni graduated from the University of Illinois Medical School and served his internship at the University of Wisconsin, Madison, family practice unit. His surgical residency also was taken in Madison. Doctor Koch, a native of Prairie du Sac, completed his medical degree at St Louis University School of Medicine. His family practice residency was taken through the Family Practice program at the University of Wisconsin Medical School in Madison.

Henry Katz, MD

. . . Manitowoc, recently joined the staff at the Medical Arts Building in the practice of dermatology. Doctor Katz graduated from Marquette University School of Medicine and interned at St Joseph Hospital in Milwaukee. His residency training in dermatology was taken at the Marshfield Clinic and at the University of

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Wisconsin in Madison. He served in the United States Navy for two years and was chief of the dermatology department. During this time, he also was assistant clinical professor of dermatology at the University of Tennessee Hospital, Memphis.

E Michael Schneeberger, MD

. . . Stevens Point, recently became associated with the Rice Clinic, SC, in the Department of Internal Medicine. A 1974 graduate of the University of Wisconsin, Madison, Doctor Schneeberger completed his internship and residency at the University of Nebraska Medical Center in Omaha.

Philip H Walker, MD

. . . has joined the medical practice of MDs Frederick P Nause,* Christopher Graf,* Thomas Mockert,* and William Forkner* in Sheboygan. Doctor Walker graduated from the University of Illinois College of Medicine, Chicago, in 1974. He completed his internship and residency program in internal medicine at Creighton University, Omaha, Neb.

John J Rank, MD

. . . Green Bay, recently joined the medical staff of the West Side Clinic. He graduated from the University of Wisconsin, Madison, in 1971 and interned at Baylor University Medical Center, Dallas, Tex. Doctor Rank served in the United States Army from 1972-74 and completed his residency in internal medicine at Mt Sinai Medical Center, Milwaukee.

David J Hendrickson, MD

. . . recently joined St Michael's Hospital, Stevens Point, in the Department of Emergency Services. Doctor Hendrickson graduated from the University of Wisconsin Medical School, Madison, and served his internship at St Paul-Ramsey Hospital and Medical Center, St. Paul, Minn. Prior to joining the medical staff at St Michael's Hospital, Doctor Hendrickson was serving at St Mary's and Madison General hospitals, Madison, and St Clare Hospital in Baraboo.

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Myron (Mike) G Spooner, MD
. . . Beloit, has joined the medical staff of the Beloit Clinic in the Department of Obstetrics and Gynecology. A graduate of the Northwestern University School of Medicine, Doctor Spooner completed projected service with the United States Navy's Berry Plan. He also was chief resident of obstetrics and gynecology at Johns Hopkins Hospital in Baltimore, where he served his internship and residency.

Thomas J Thomas, MD
. . . recently became associated with the medical staff of the Cantwell-Peterson Clinic in Shawano. Doctor Thomas graduated from the Univerversity of Wisconsin Medical School, Madison, and completed his family practice residency at Mercy Hospital in Denver, Colorado.

Thomas E Brown, MD
Roger K Resar, MD
. . . have joined the medical staff of the Midelfort Clinic, Eau Claire. Doctor Brown graduated from the University of Wisconsin Medical School, Madison, and served his residency at New York Hospital-Cornell Medical Center, New York. His final year in

continued on page 46

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1 Dane County Medical Society HMP Committee
3 WisPRO Review and Evaluation Committee
3 T-19 Provider Groups
3 SMS Commission on Mediation and Professional Ethics
4 Task Force on Health Screening and Immunization
5 SMS Realty Corporation Board of Trustees
5 *Executive Committee of SMS Council (Madison)*
6 Finance Committee of SMS Council
6 Committee on Economic Medicine of SMS Council
6 Nominating Committee of SMS Council
6 SMS Council
10 WisPRO Criteria Committee
16 Advisory Committee on Health Education
18 State Steering Committee on H-24
24 WisPRO Executive Committee
24 Medical Care Evaluation Committee
25 SMS Committee on Aging and Extended Care Facilities
29 Dane County Medical Society HMP Committee
31 SMS Committee on Federal Legislation
31 SMS Commission on Governmental Affairs

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parenthesis.

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Dollar Range Per Transaction	Commission Rates
$ 0 - 2,500	1.6% not less than $ 24
2,501 - 5,000	1.2 " " " 40
5,001 - 9,000	1.0 " " " 60
9,001 - 15,000	.8 " " " 90
15,001 - 25,000	.6 " " " 120
25,001 - 50,000	.5 " " " 150
50,001 - ABOVE	NEGOTIABLE*

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100	55	80.73	40.00	40.73	50
200	20	77.00	48.00	29.00	38
500	25	204.31	100.00	104.31	51
1000	5	139.70	60.00	79.70	57

OPTIONS SCHEDULE

CBOE, American, Pacific, Midwest and Philadelphia Stock Exchanges

Dollar Range Per Transaction	Commission Rates
$ 0 - 2,500	2.0% not less than $ 24
2,501 - 3,500	1.7 " " " 50
3,501 - 6,500	1.5 " " " 60
6,501 - ABOVE	NEGOTIABLE**

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Minimum Per Contract Up To 20 Contracts Over 20 Contracts, Entire Order Negotiable	$3
Maximum Commission Per Contract	$40

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COMPARE OUR EXAMPLES

Options Per Order	Price Per Option	Old CBOE* Commission	Schwab & Co. Comm.	$ YOU Save	% YOU Save
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5	2	55.00	24.00	31.00	56
3	7	57.30	42.00	15.30	27
20	1	138.00	60.00	78.00	57

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continued from page 44

residency was at Memorial Hospital-Sloan Kettering Cancer Center doing surgical oncology. Doctor Resar, formerly of Park Falls, graduated from the University of Wisconsin Medical School, Madison, and served his residency in pulmonary diseases at the University of Arizona, Tucson.

Jane Borish, MD
William W Grosh, MD

. . . Park Falls, recently became associated with the Murphy Clinic. Doctor Borish graduated from the Medical College of Pennsylvania and completed her family practice residency at St Luke's Hospital, Bethlehem, Pa. An internist, Doctor Grosh served his residency with Vanderbilt University Medical Center, Nashville, Tenn. He graduated from Columbia University College of Physicians and Surgeons, New York, in 1974.

Rolf Hanson, MD

. . . recently joined the medical staff of the Southern Price County Medical Center in Phillips. Doctor Hanson graduated from the University of Minnesota Medical School in 1974 and completed an internship at Cook County Hospital, Chicago, followed by his family practice residency. Doctor Hanson will be serving a two-year period under a program of the National Health Service Corps.

David Hogue, MD

. . . Eau Claire, recently opened his medical practice in ophthalmology. He received his medical degree from the University of Cincinnati, Cincinnati, Ohio, in 1971 and served his internship at Milwaukee County General Hospital. His residency was taken at the Medical College of Wisconsin in Milwaukee. Doctor Hogue also served in the United States Air Force for two years.

Kathryn Chizek Bemmann, MD*

. . . Waukesha, recently was honored by induction as a fellow in the American Psychiatric Association. Doctor Bemmann is president of the Milwaukee chapter, Wisconsin Psychiatric Association and chairperson of the Wisconsin Psychiatric Association Committee on Women. She also is co-director of the newly reactivated American Medical Women's Association, Southeastern Wisconsin Branch. Doctor Bemmann has been active in promoting improved medical treatment of sexual assault victims in southeastern Wisconsin, in such capacities as chairperson of the Sexual Assault Services Coordinating Committee of Waukesha County and as an advisory council member of the Sexual Assault Treatment Center, Milwaukee. ■

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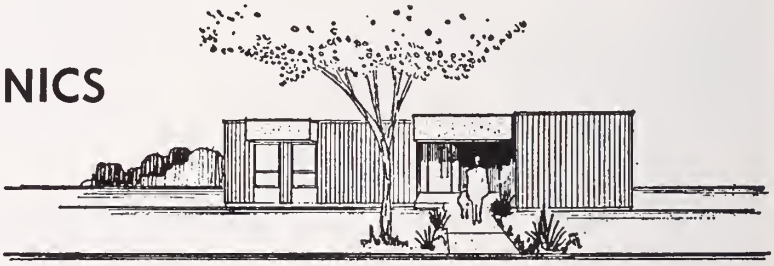

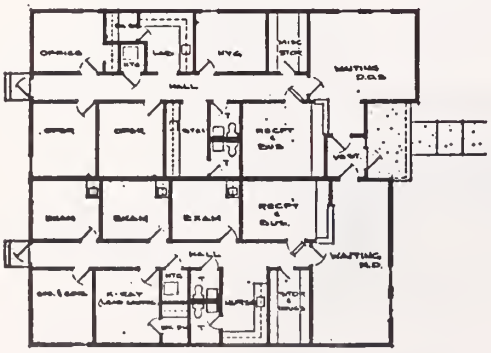

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WPS

report

for Wisconsin Physicians

Volumn VI, Number 5

September 1977

MEDICAL NECESSITY PROGRAM ANNOUNCED

There are many reasons for the increasing costs of health care: inflation, population increases, soaring professional liability premiums, new technology such as the CAT Scanner, new techniques like the coronary by-pass, and the effect of government actions.

On May 18, 1977, the Blue Shield Association launched a campaign to combat health care cost increases while upgrading the quality of that care.

Called the Medical Necessity Program, the campaign's purpose is to isolate and discontinue **routine** payment for certain procedures: new procedures of unproven value, established procedures of questionable use, procedures which are redundant in combination with other procedures and procedures which, when repeated, do not provide the physician with additional information. A listing of the selected procedures can be found on the following page.

The Medical Necessity Program was developed by the Blue Shield Organization following the recommendations of numerous professional organizations: American College of Physicians, American College of Radiology, and American College of Surgeons. Other societies consulted were the American Academy of Family Practice, Council of Medical Specialties, Blue Cross Association, American Hospital Association and the American Association of Medical Colleges.

WPS has reviewed the procedures and agreed that they should be considered as "by report" procedures. Any claims submitted to WPS including charges for any of the listed procedures will, therefore, need to be accompanied by specific information satisfactorily establishing their medical necessity.

This initiative should not be regarded as an attempt to second-guess the physician's medical judgement. It presents an opportunity to improve medical care while holding down the costs. WPS does not intend to categorically deny payment for these procedures--there are circumstances in which nearly any procedure can be justified--but they will be paid only on submission of a report justifying their use. Furthermore, a physician's justification of a procedure may be challenged and turned over to a local review committee of physicians for further review.

At WPS, we regard the Medical Necessity Program as an important precedent in attempting to stem rising health care costs from within the health care industry. We hope that, through an exchange of information based on authoritative clinical experience, the campaign will reduce and eventually eliminate a number of costly procedures while enhancing the quality of medical care.

Because of the relevance of the Medical Necessity Program to the work of your Medical Assistants, please bring this explanation and list of procedures to their attention.

10797-017-7709

Please tear out and file with Report series in three-ring binder

Surgical and Diagnostic Procedures Specified

The following surgical and diagnostic procedures will no longer be paid on a **routine** basis by WPS; they will be paid only upon submission of a report satisfactorily establishing medical necessity.

SURGICAL PROCEDURES

Ligation of Internal Mammary Arteries, Unilateral or Bilateral: the tying of the mammary arteries.

Radical Hemorrhoidectomy, Whitehead Type: extensive surgical excision of hemorrhoids.

Omentopexy (Portal Obstruction): fastening the omentum to establish a more efficient blood flow between stomach/intestines and spleen through the liver.

Kidney Decapsulation, Unilateral and Bilateral: removal of fatty or fibrous structure which cover all or part of kidney.

Perirenal Insufflation: injecting air around the kidneys for X-ray visualization.

Nephropexy: suspension of a floating kidney.

Circumcision, Female: incision of the fold of skin over the clitoris.

Hysterotomy: cutting into the uterus for non-obstetrical reasons from a vaginal approach.

Supracervical Systerectomy: removal of the uterus leaving the cervix in place.

Uterine Suspension: suspension of the uterus to the vagina or abdominal wall.

Uterine Suspension with Presacral Sympathectomy: suspension of the uterus to the vagina or the abdominal wall with interruption of the sympathic nerve pathways in front of the sacrum.

Hypogastric or Presacral Neurectomy: excision of part of the hypogastric or presacral nerve (plexus).

Ligation of Thyroid Arteries (Independent Procedure): tying the arteries which supply the thyroid gland and adjacent structures with blood.

Fascia Lata by Stripper When Used To Treat Lower Back Pain: repair of the sheath of connective tissue which covers or binds body parts together.

Fascia Lata by Incision When Used To Treat Lower Back Pain: repair of the connective tissues which covers or binds body parts but with the fascia incised and removed.

Ligation of the Femoral Vein, Unilateral and Bilateral, When Used To Treat Post-Phlebitic Syndrome: tying of the femoral vein for post-phlebitic syndrome complications.

Excision of the Carotid Body Tumor When Used To Treat Asthma: removal of round mass on or near the carotid artery.

Sympathectomy, Thoracolumbar, Unilateral and Bilateral, When Used To Treat Hypertension: interruption of some portion of the sympathetic nerves in the back.

Sympathectomy, Lumbar, When Used To Treat Hypertension: interruption of some sympathetic nerves in the lower back region.

Splanchnicectomy, Unilateral and Bilateral, When Used To Treat Hypertension: excision of part of one of the splanchnic nerves in the chest and lower back.

DIAGNOSTIC PROCEDURES

Basal Metabolic Rate: determines how the body expends energy.

Protein Bound Iodine (PBI): measures the level of circulating thyroid hormones.

Icterus Index: measures the presence of jaundice.

Ballistocardiogram (BCG): measures the amount of blood a heart can put out in a given unit of time.

Phonocardiogram With Interpretation and Report and With Indirect Carotid Artery Tracing or Similar Study: records various heart sounds.

Angiocardiography Using Carbon Dioxide, Supervision and Interpretation Only: X-ray of the heart after carbon dioxide has been injected.

Angiocardiography, Single Plane, Supervision and Interpretation Only and in Conjunction With Cineradiography: X-ray of the heart taken from a single angle in conjunction with motion pictures of the heart.

Angiography-Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View Unless in an Emergency: photography of the coronary arteries after a radiopaque substance injected into bloodstream.

Angiography Extremity Unilateral, Supervision and Interpretation Only, Single View Unless Emergency: photography of the arteries of the arms and legs.

Bronchoscopy With Injection of Contract Medium for Bronchography.

Bronchoscopy With Injection of Radioactive Substance.

Two procedures of unproven value which require written justification of medical necessity are "fabric wrapping of abdominal aneurysm" and "extra-intra cranial arterial bypass for stroke".

*Please tear out and file with **Report** series in three-ring binder.*

PHYSICIANS: PRACTICES AND positions. We are specialists in the medical staffing field and provide a unique service to physicians seeking a meaningful affiliation as well as medical organizations desiring to enhance their expanding staffs. Due to our unlimited national exposure to qualified physicians and organizations, we are able to identify, isolate and select only those medical professionals who best satisfy your individual requirements. Our service eliminates unnecessary involvement and misdirected time and energy, leaving you the ultimate task of choosing the most desirable affiliation or candidate from those currently available. Our consultants are dedicated to locating that particular practice or ideal medical associate in order to increase your health-care capabilities through mutual compatability and harmony. Relocation and placement expenses are assumed by client organization or group. For personal service regardless of medical specialty forward position specifications, resumé or vitae in confidence to: John Rafferty, Medical Staffing Administrator, H S Placement Service, Inc, PO Box 3247, Green Bay, WI 54303. Tel: 414/494-9586. 8-9/77

CLINICAL DIRECTOR PSYCHIAtrist—Exciting opening to join a progressive, innovative staff in a beautiful rural area serving Southwest Wisconsin. Program includes a wide range of owned and operated services including a small psychiatric and drug treatment hospital, outpatient and day services. The clinical director will have supervisory responsibility for the clinical services provided to developmentally disabled, mentally ill and chemically dependent clients. Salary is negotiable for this full-time position which includes a liberal fringe benefit package. For more information contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, Box 351, Lancaster, Wis 53813. Tel: 608/723-7430. 9/77*

WANTED: PHYSICIANS — ALL specialties. As search consultants in the health-care field, we are interested in physicians with a good career path for full-time positions as Medical Director, Assistant Medical Director, Chiefs of Clinical Departments, and clinical practice with our clients, blue-ribbon hospitals and other organizations in the health-care field. We invite your curriculum vitae so that we may contact you when the right situation develops. No financial obligation to candidate. Lepinot Associates, Inc, 702 Abbott Rd, East Lansing, Mich 48823. 9,12/77

WELL-ESTABLISHED FAMILY Practitioner seeking associates in small, friendly community. Access to four excellent medical facilities. Fox River Valley area. Partnership potential. Reply to Box 242, Little Chute, Wis 54140. p9-11/77

WANTED: GENERAL SURGEON, board certified or eligible to join eight man family practice group in University town with trade area population of 22,000, 30 miles southeast of St Paul, MN. JCAH approved hospital. Contact David Woeste, MD, River Falls Medical Clinic, Ltd, River Falls, Wis 54022, or call collect 715/425-6701. 9tfn/77

MEDICAL DIRECTOR-WISCONSIN State Prison, Waupun, Wis, must be eligible for licensure to practice medicine in Wisconsin. Duties: Supervise and provide medical services to residents at maximum security adult male correctional institution, responsible for administration of hospital, coordinate activities within hospital with other outside medical facilities. Pay: Start between $14.730 per hour ($2563 per mo) and $18.056 per hour ($3141 per mo) based upon qualifications of applicant. Receive increase after six months. Equivalent salary: Approx $31,860 to $38,796 annually. Waupun is attractive community of 8000, varied recreational facilities, excellent school system, near Horicon Marsh Wildlife Refuge. Write to Glenn R Weeks, Personnel Manager, Box C, Waupun, Wis 53963. An Equal Opportunity Employer Functioning Under An Affirmative Action Program. 9-10/77

EMERGENCY PHYSICIAN: PARTtime ER physician wanted for one or two weekends a month in a quiet emergency department. Work 12 to 60 hour shift. $20 per hour plus use of furnished home adjacent to hospital. Conscientious back-up by medical staff. Wisconsin license and malpractice insurance required. Contact Philip T Eckstrom, MD, Rt #1, Box 254, Peshtigo, Wis 54167. Tel: 715/582-3315. p9-10/77

MEDICAL FACILITIES

FOR RENT: MEDICAL OFFICES located in Milwaukee suburb. Air-conditioned, carpeted, parking lot. Share lab, x-ray, and switchboard facilities. Phone 414/771-0500 for daytime and 414/781-1497 nights. 9-10/77

ONE MOBILE RADIOGRAPHIC x-ray facility in excellent condition for sale or lease. Completely self-contained x-ray laboratory, consisting of a 22 foot air conditioned and vandal-protected Winnebago van, condenser discharge x-ray system with tubestand and table, Dupont daylight film loading system, Kodak automatic cold water film processor and all accessories. Very useful for care of nursing home patients, industrial screening examinations, athletic events, or disaster work. Contact Drs Perilla, Sindler, & Assoc, PA, 3350 Wilkins Ave, Baltimore, MD 21229. p9/77

FOR SALE: ENTIRE OFFICE AND medical equipment of deceased doctor who was engaged in general practice and surgery in the Village of Waterford, Racine County, Wis. Office used by doctor available for lease. Call 414/539-2868. g9tfn/77

FOR SALE: MEDICAL BUILDING; waiting room, reception desk, lab room, eight examining rooms. Pharmacy in building (also for sale). Located in a rapidly growing area of Sturtevant, Wis, Four miles west of Racine. Please write or call collect to Robert C Cotter, RPh, 8700 Racine Ave, Hwy 11, Sturtevant, Wis 53177. Tel: 414/886-4178. 9-10/77

WANTED TO BUY: EXAMINAtion room table, horizontal file, cabinets, office furniture, etc. Contact: E G Arellano, MD, tel: 414/324-5043 or 414/324-5581. 5tfn/77

OFFICE SPACE FOR RENT: Courtland Medical Center Building. Excellent location - 68th at West Capitol Drive, Milwaukee, Wis. Full lab and x-ray facilities available. Call 414/463-3704. 3/77*

FOR SALE: MEDICAL BUILDING. Presently leased to two dentists and two MDs. 33-car parking lot, air-conditioned, Northeast Madison. Beautifully maintained, priced to sell. Joha Realty Co. Tel: 608/241-2083 8-9/77*

FOR LEASE: OFFICE SPACE. Professional building, 2888.5 sq ft. Reception room, air-conditioned, 33-car parking lot, can accommodate 2 to 3 MDs, Northeast side of Madison. Joha Realty Co. Tel: 608/241-2083. 8-9/77*

MEDICAL OFFICE FURNITURE: Examining table, upright cabinet, equipment table, desk with chair and 6 wooden arm chairs—used in waiting room. Will contribute to anyone who will pay the cost of moving them. Contact Mrs John M Albino, 438 Shoreland Dr, Racine, Wis 53401. g8tfn/77

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

AVAILABLE FOR MULTIPURpose uses; *eg*, outpatient, ambulatory care, clinic, group practice. Former hospital building at 1971 W Capitol Dr, Milwaukee. Two-story brick, air-conditioned, sprinklered. Tel: 312/746-1971. p8-9/77

RETIRED GENERAL SURGEON'S professional equipment for sale. Can be purchased in entirety or separately. Call 608/846-5661 between 8:30-10 PM. 8/77*

METHODS OF BURN TREATMENT

Second International Burn Symposium of St Mary's Hospital, Milwaukee

January 28-29, 1978

Co-chairmen: Burton A Waisbren, MD, Director of the Burn Research and Clinical Paradigm Laboratory and Associate Director of the Burn Center; and George E Collentine, Jr, MD, Director of St Mary's Burn Center.

Proof of Efficacy of Methods of Burn Treatment—Alternate Pathways will be the subject of the two-day session in which the foremost international burn surgeons will be allowed to present a specific method of burn treatment to an expert panel of critiquers, who will analyze the results. The audience will also be allowed to critique the presentations.

Presenters:

—**William F Monafo, MD,** Dept of Surgery, St John's Mercy Medical Center, St Louis, Mo.

—**Burton A Waisbren, MD,** St Mary's Burn Center.

—**George B Hart, MD,** Long Beach Hyperbaric Center, Long Beach, Calif.

—**John F Burke, MD,** Shriners Burns Institute, Boston, Mass.

—**Bent Sorensen, MD,** Professor of Surgery, University of Copenhagen, Denmark.

—**J Wesley Alexander, MD,** Shriners Burns Institute, Cincinnati, Ohio.

—**Irving Feller, MD,** University of Michigan Burn Center, Ann Arbor.

The first St Mary's Symposium dealt with the issue of skin banking. The objective of this session is to help those engaged in the treatment of burns to decide whether there is enough evidence for them to justify the use of the new modalities being discussed. Furthermore, the intimate exposure with the foremost experts on experimental design in this country will allow them to more scientifically evaluate and present new methods of treatment that they may develop.

For additional information contact Peter Hanson or Mary Sparks, 414/289-7144 at St Mary's Hospital, Community Relations Department, Milwaukee, 2323 North Lake Drive, PO Box 503, Milwaukee, Wis 53201.

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1977 WISCONSIN

Sep 29: *Breast Carcinoma:* Third Annual Medical Symposium sponsored by Bellin Memorial Hospital, Green Bay. Seven (7) prescribed hours of credit, AAFP. Request further information from: Jack A Killins, MD, Symposium Chairman, Bellin Memorial Hospital, PO Box 1700, Green Bay, Wis 54305.

Sept 30-Oct 1: *Cost Containment and Cost Controls—Where Are We Headed?,* at University Bay Center, UW-Madison Campus. See details elsewhere in this section.

Oct 6-7: First meeting of Wisconsin Chapter of American College of Emergency Physicians, at Marc Plaza Hotel, Milwaukee. CME credit will be given. Further details appeared in the August issue.

Oct 6-8: *Clinical Applications of Nuclear Cardiology,* sponsored by Mount Sinai Medical Center and its Soref Heart Center, at the Red Carpet Inn, Milwaukee. See details elsewhere in this section.

Oct 7: *Primary Prevention Workshop,* presented by Mendota Mental Health Institute. Info: In-service and Community Training Unit, Mendota Mental Health Institute, 301 Troy Dr, Madison Wis 53704; tel: 608/244-2411.

Oct 7-8: *Geriatric Seminar: What's New for the Old.* Sponsored by Dept of Family Practice, Medical College of Wisconsin, and American Geriatrics Society. Mequon Care Center, Mequon (near Milwaukee). See details in August issue.

Oct 7-9: Wisconsin Radiological Society, Concourse Hotel, Madison.

Oct 8: *Fall Cancer Conference,* sponsored by Wisconsin Clinical Cancer Center/American Cancer Society/UW-Extension, CME Department; at University of Wisconsin Hospitals, Madison. See details elsewhere in this section.

Oct 18: *Work Week of Health,* Eau Claire Civic Center.

Oct 19: *Work Week of Health,* Winnebago Mental Health Institute.

Oct 19: *Green Bay One-day Seminar for Family Physicians,* at Bellin Memorial Hospital. Further details later.

Oct 19-21: Wisconsin Nurses Association Convention, Olympia Princess, Resort (at Scotsland), Oconomowoc. See boxed announced elsewhere in this section.

Oct 21-22: *Worker's Compensation Injuries—Contemporary Management of Pains and Claims,* at St Francis Hospital in LaCrosse. See details elsewhere in this section.

Oct 29: *Breast Cancer; Development, Detection and Diagnosis,* Continuing Education Course at Veterans Administration Hospital, Wood, Wis. Four hours Category I credit by AMA-PRA. Info: Thomas J Imray, MD, Dept of Radiology, Milwaukee County General Hospital, 8700 W Wisconsin Ave, Milwaukee, WI 53226.

Nov 12: *Current Advances in Diagnosis and Treatment.* St Joseph's Hospital Clinic Day, Milwaukee, Wis. Guest speakers, Drs Jay Sanford and Jack McGiff. Info: Thomas P Driscoll, MD, St Joseph's Hospital, 5000 W Chambers St, Milwaukee, Wis 53210.

Nov 16: *Green Bay One-day Seminar for Family Physicians,* at St Vincent Hospital. Further details later.

1978 WISCONSIN

Jan 19-21: *Winter Refresher Course for Family Physicians.* Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians. Pfister Hotel and Tower, Milwaukee.

1978 WISCONSIN

Jan 28-29: St Mary's Hospital International Burn Symposium, Milwaukee. See details elsewhere in this section.

Mar 30-Apr 1: Second Annual Ophthalmology Current Concepts Seminar '78 of the University of Wisconsin-Madison. Lectures and Workshops. Sponsored by the Dept of Ophthalmology Faculty, University Hospitals, Madison.

1977 NEIGHBORING

Oct 15: CME Program: *Law for Physicians,* Thomas G Baffes, MD, JD, Moderator. Speakers: Harold Jacobson, Philip Corboy, John Hayes, and Howard Gilbert, attorneys; and Hon David Canel, Judge, District Court of Cook County. At Mt Sinai Hospital, 15th St & California Ave, Chicago, Ill 60608. Preregistration fee: $40, Office of Medical Education (312) 542-2562. Approved for 5 hours of Category I credit for AMA-PRA. g8-9/77

Oct 26-28: *Rights of children as research subjects* will be argued in a conference at the University of Illinois at Urbana-Champaign. Sessions to be held at Ramada Inn, Champaign. Info: Ronald G Sears, Conference Director, 116 Illini Hall, University of Illinois, Champaign, Ill 61820. g6-9/77

1977 OTHERS

Oct 5-8: Annual Meeting, American Group Practice Association, Houston, Texas. Info: AGPA, Educational Services Office, 20 S Quaker Lane, Alexandria, Va 22314. g8-9/77

Oct 17-22: *Eighth National Symposium and Workshop on Protecting the Abused, the Neglected, and the Sexually Exploited Child,* at the Sheraton Waikiki in Honolulu, Hawaii. Info: American Humane Association, Children's Division, PO Box 2788, Denver, Colo 80201. g7-9/77

Oct 31-Nov 1-3: *62nd Annual International Scientific Assembly of Interstate Postgraduate Medical Association,* at Diplomat Hotel in Hollywood, Fla. Further info: Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701. g6-9/77

Nov 4-5: *Conference on Cancer of the Bladder and Prostate,* American Cancer Society-Kentucky Division, at Stouffer's Inn, Louisville, Ky. Info: George A Sehlinger, MD, President, ACS-Kentucky Div, 2313 Medical Arts Bldg, Louisville, Ky 40217. g5-10/77

CLINICAL APPLICATIONS OF NUCLEAR CARDIOLOGY

Sponsored by—

Mount Sinai Medical Center and its Soref Heart Center

at the Red Carpet Inn
Milwaukee

Thursday through noon Saturday October 6-8

Specialists in the field from throughout the country will serve as faculty for this second annual conference.

Nuclear cardiology is a rapidly growing method of studying the heart through the use of radioactive material and a special camera. A radioactive isotope is placed into the bloodstream, usually by injection into a vein. Using the special camera, a physician is able to watch the isotope as it is taken up by or passes through the heart. Nuclear cardiology is "non-invasive" in that nothing is inserted into the heart, as is the case in catheterization.

Faculty, named thus far—

William L Ashburn, MD, professor of radiology and head of the division of nuclear medicine at the San Diego Medical School of the University of California.

Glen W Hamilton, MD, chief of the nuclear medicine section at the Veterans Administration hospital in Seattle and associate professor of medicine at the University of Washington.

W Dudley Johnson, MD, head of cardiovascular surgery at Mount Sinai Medical Center and associate clinical professor of surgery in the department of thoracic cardiovascular surgery at the Medical College of Wisconsin in Milwaukee.

Robert H Jones, MD, assistant professor of general and cardiothoracic surgery at Duke University Medical Center and an investigator for Howard Hughes Medical Institute.

William J MacIntyre, PhD, a physicist in the department of nuclear medicine at the Cleveland Clinic Foundation and president of the national Nuclear Medicine Society.

Heinrich R Schelebert, MD, associate professor of radiologic sciences in the division of nuclear medicine at the University of California, Los Angeles.

Salvadore Treves, MD, chief of pediatric nuclear medicine at Children's Hospital in Boston and associate professor of radiology at Harvard Medical School.

Barry Zaret, MD, associate professor of medicine and diagnostic radiology at the Yale University School of Medicine.

Donald H Schmidt, MD, head of the cardiovascular disease section at Mount Sinai and associate professor of medicine at the University of Wisconsin Medical School, is serving as program chairman.

Cosponsoring the symposium are the Wisconsin affiliate of the American Heart Association; Society of Nuclear Medicine; University of Wisconsin-Madison Center for Health Sciences; and Department of Continuing Medical Education, Health Sciences Unit of the University of Wisconsin-Extension.

Wisconsin Nurses Association Convention/*Nursing Practice Tomorrow-Today's Commitment*

October 19-21, Olympia Princess Resort, Scotsland, Oconomowoc

Wednesday, October 19

General Session, Speaker Joy Calkin, RN

Conflict: A Cornerstone of Change

Banquet Speaker: Dolores E Little, RN

Thursday, October 20

Section and conference group programs include:

- *Research and Nursing Service: Implementation and Implication*
- *The Hospice Concept*
- *Role of the Occupational Health Nurse*
- *Legal Implications for Clinical Nurse Specialists*
- *Delivering Quality Nursing Care Within the Legislative Guidelines*
- *Sudden Infant Death Syndrome*
- *Variety: The Spice of Psychiatric Nursing in Wisconsin*

General Session, Speaker M Lucille Kinlein, RN

- *Movement Toward Autonomy in Nursing Practice*

Friday, October 21

General Session

- *Board of Nursing's Approach to Determine Current Competency of Nurses Authorized to Practice Nursing*

Clinical Sessions

- *Implementation of Standards of Practice*
- *Legalizing Levels of Nursing Practice—Is 1985 a Realistic Goal?*
- *Nurses Deserve More*
- *Human Sexuality*

Info: Wisconsin Nurses Association, Inc, 161 West Wisconsin Ave, Milwaukee, Wis 53203 Tel: 414/272-3670

University of Wisconsin-Madison Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

CME Calendar—1977-1978

Oct 11: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Oct 19: *Maternal and Infant Care: Special Neonatal Problems I,* Beaver Dam Community Hospitals, Beaver Dam.

Oct 21: Annual Fall Pediatrics Day, *New Trends in Clinical Pediatrics,* at Howard Johnsons Motor Lodge, Madison.

Oct 25-28: *Educational Resources,* University Bay Center, Madison.

Oct 26-28: *50th Anniversary Preceptorship Program,* The Wisconsin Center, Madison

Nov 3: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Nov 3-5: *Interventional Radiology,* The Wisconsin Center, Madison.

Nov 8: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Nov 16: *Maternal and Infant Care: Special Neonatal Problems II,* Beaver Dam Community Hospitals, Beaver Dam.

Dec 21: *Maternal and Infant Care: Optional Assessment of Series,* Beaver Dam Community Hospital, Beaver Dam.

Jan. 10: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Feb. 8: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Feb 14: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Mar 14: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Apr 11: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Apr 11-12: *Patient Education,* The Concourse Hotel, Madison.

Apr 13-15: *Seminar-Workshop in Radiology,* The Wisconsin Center, Madison.

Apr 21-22: *Conference on Dermatology,* The Wisconsin Center, Madison.

Info: Coordinator, Dept of CME, 601 Walnut Street, Madison, Wis 53706; phone: 608/263-2850.

1977 AMA

Oct 7-9: AMA Regional CME Meeting, Sawmill Creek, Huron, Ohio.

Oct 30-Nov 4: AMA Regional CME Meeting, Honolulu, Hawaii.

Nov 10-11: AMA 16th National Conference on Physicians and Schools, Regency Chicago, Chicago.

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Dec 20-23: AMA National Leadership Conference.

Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

1978 OTHERS

Jan 28-29: Second International Glaucoma Congress, at Americana Hotel in Miami Beach, Fla. Being held in conjunction with Annual Scientific Assembly of American Society of Contemporary Ophthalmology, Jan 30-Feb 3. Info: Dr John Bellows, Director, 6 North Michigan Ave, Chicago, Ill 60602. g8-12/77

Jan 30-Feb 3: Annual Scientific Assembly of American Society of Contemporary Medicine and Surgery, at Americana Hotel in Miami Beach, Fla. Meets criteria for 40 hours of credit in Category I for AMA-PRA. Info: John G Bellows, MD, PhD, Director, 6 North Michigan Ave, Chicago, Ill 60602; (312) 236-4673. g8-12/77 ■

COST CONTAINMENT AND COST CONTROLS—WHERE ARE WE HEADED?

The University Bay Center—Madison—September 30-October 1

Seminar will examine the current concern over escalation of costs in health care, and especially in the hospital. Cost containment and cost controls are currently being pushed by President Carter's Administration, and supported to varying degrees by the Congress. Also the seminar will focus on health-care costs, how controls might affect the quality of care and the administration of the hospital. The future of health administration within cost constraints, which are sure to be imposed, will also be discussed; ie, the federal, state, and private perspectives. Particularly interested will be hospital governing boards, medical staffs, and chief executive officers of hospitals, chief executive officers of clinics and health systems agency staffs.

Clinics, and particularly physicians, will not only be affected by the cost containment and cost control efforts developed for the hospital but also it may be that hospital controls are a harbinger of controls on physicians' fees which might be the next step taken in the whole control process.

Faculty:

—**Ralph Andreano, PhD,** Administrator, Division of Health; Professor of Economics, Program in Health Services Administration, UW-Madison

—**James Bjorkman, PhD,** Assistant Professor of Preventive Medicine and Political Science, Program in Health Sciences Administration, UW-Madison

—**Don Detmer, MD,** Associate Professor of Preventive Medicine and Surgery, Program in Health Services Administration, UW-Madison

—**John Alexander McMahon,** President, American Hospital Association

—**James J Mongan, MD,** Staff, US Senate Finance Committee

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Program concludes prior to the Wisconsin-Northwestern football game at Camp Randall Stadium, Madison.

Registration fee $50 to UW-Extension, Health Sciences Unit, Dept of CME, 610 N Walnut St, Madison, Wis 53706.

Credit of 8.5 credit hours in Category 1 towards AMA-PRA; also 8.5 Continuing Education Hours (CEHs) by UW-Extension.

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University of Wisconsin-Extension, Health Sciences Unit, Department of Continuing Medical Education in conjunction with programs in Health Services Administration, University of Wisconsin-Madison, Center for Health Sciences, School of Medicine, and Wisconsin Hospital Association.

1977-1978 Madison
In-Depth Teaching Programs

Preliminary Schedule

Nov 17, 1977—(Thursday) University Hospitals

Dec 21, 1977—(Wednesday) Madison General Hospital

Jan 19, 1978—(Thursday) St Marys Hospital Medical Center

Feb 15, 1978—(Wednesday) Methodist Hospital

WORKER'S COMPENSATION INJURIES—Contemporary Management of Pains and Claims

October 21-22—LaCrosse
St Francis Hospital

Cosponsored by the Pain and Health Rehabilitation Center, St Francis-Mayo Family Practice Residency, and University of Wisconsin-Extension/Health Sciences Unit/Department of Continuing Medical Education

Conference is designed to encourage physicians and insurance carriers to consider comprehensive pain assessment prior to any elective surgery. In addition, contemporary methods of achieving rehabilitation with minimal use of drugs or surgery will be emphasized.

Faculty include:

—**Rolland Martin, MD,** Medical Director, Oregon Worker's Compensation Board

—**Joel L Seres, MD,** Director, Northwest Pain Clinic, Oregon

—**C Norman Shealy, MD, PhD,** Director, Pain and Health Rehabilitation Center, LaCrosse

—**Donald J Sherman, MD,** Chief Physician, Ford Motor Company, Metuchen Assembly Plan

—**Norman J Taugher,** Administrator, Wisconsin Worker's Compensation Division

—**Ann Walsh, JD,** Attorney for Employers Insurance of Wausau

Fee: $45 for Friday or $60 for Friday and Saturday. Registration with CME Coordinator, The Wisconsin Center, 702 Langdon St, Madison, Wis 53706.

FALL CANCER CONFERENCE

Sponsored by WCCC-ACS

UWEX-CME Department

Saturday, October 8, Madison

University of Wisconsin Hospitals
1300 University Avenue
Room 227, SMI Building

PROGRAM

Paul P Carbone, MD, Moderator
9 AM—*Immunotherapy—Melanoma:* Ernest C Borden, MD; Alan Coates, MD

10 AM—*Role of Diet in Cancer Etiology—Perspectives on the Saccharin Controversy:* Raymond R Brown, MD; George T Bryan, MD

11 AM—*Testicular Tumors:* Thomas E Davis, MD; William L Caldwell, MD

12 N—Lunch: UWH Cafeteria
For registration, contact the American Cancer Society: (608) 249-0487. Registration fee: $5.00 includes coffee break and lunch.

For information about tickets to the Illinois-Wisconsin football game, contact the American Cancer Society.

THE FINANCING OF MEDICAL CARE

10th Annual Workshop of the Institute of Medicine of Chicago

Continental Plaza Hotel, Chicago

Friday, November 11

8:00 am to 5:00 pm

Are consumer health care demands realistic in terms of actual health care needs?

How Will Rising costs in the financing of health care affect undergraduate and graduate medical education?

Governmental, academic and private insurance company solutions to these problems will be subjects for panel and general discussion along with advantages and disadvantages of "capping" hospital payments and other means of cost containment in every phase of health care.

Registration ($45 for nonmembers, $40 for members) includes luncheon and coffee breaks.

For information, write Institute of Medicine of Chicago, 332 South Michigan Ave, Chicago, Ill 60604, or call 312/663-0040.

CONTRIBUTIONS—CES FOUNDATION
July 1977

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for July 1977.

Unrestricted

Waukesha County Medical Society Auxiliary; John Allen, MD—*Voluntary Contributions*

Restricted

Deborah J Erwin—*Academy of Medical History*
Membership Dues—*Aesculapian Society*
Waukesha Family Practice Center; John Honish, MD; Osseo Medical Center; Clinic Building Account-Baldwin; Wisconsin Rural Rehabilitation Corp; FM Schammel, MD; Robert Handeyside, MD; Sauk Prairie Memorial Hospital; Neillsville Clinic; Memorial Hospital-Neillsville; Kaukauna Clinic; JH Zellmer, MD; St Croix Falls Clinic; Surgical Care Blue Shield—*Medical Student Summer Externship Program*

Memorials

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Dick and Marge Stafford—*Earl Van Galder*

NEW GENERIC DRUG FORMULARY ISSUED

A new list of the Generic Drug Formulary, which became effective September 1, 1977, was to be mailed in mid-September to every prescriber, pharmacist, and pharmacy in Wisconsin. Prescribers include physicians, osteopaths, podiatrists, and dentists. The State Department of Health and Social Services revises the Formulary twice each calendar year to include the latest approved equivalent drugs under Chapter 168 of the Wisconsin Statutes.

EMERGENCY PHYSICIANS TO MEET

The Wisconsin Chapter of the American College of Emergency Physicians, in conjunction with the Emergency Nurses Association, has scheduled its first state meeting for October 6 and 7 in Milwaukee. The program will focus on the development of emergency services in Wisconsin and, in particular, the EMS system in Milwaukee. Physicians who attend the program will receive 12 hours of Category I Continuing Medical Education credit. The topics to be discussed include: "The Need for Emergency Medicine," "The Place of Emergency Medicine in the Medical School Curriculum," and "Cardiac Care in the Emergency Department."

FDA BANS PHENPHORMIN

Physicians have only a 90-day transition period in which to change diabetes patients being maintained on phenphormin (DBI, Meltrol) to insulin or some other diabetes therapy. The FDA's order came July 26. The FDA said phenphormin is thought to be a prime cause of lactic acidosis. It will remain available for people working in hazardous occupations where the possibility of going into insulin shock would be an overriding health problem, and for people who are unable to administer insulin to themselves.

SMS AND MEDICAL EXAMINING BOARD TO COLLABORATE

Officers of the State Medical Society met recently with members of the Wisconsin Medical Examining Board and agreed that physicians and staffs of the two groups should work together on better methods to expedite complaints and the handling of disciplinary problems; SMS offered to provide consultative peer review assistance to the Board upon request.

NEW YORK TO ALLOW PHYSICIANS TO ADVERTISE

The New York State Board of Regents has ruled that physicians and other professionals in that state may now advertise their fees and services in newspapers and magazines. In addition, professionals may advertise their services, but not their fees, on television and radio. The ruling, which applies to all professionals except lawyers and clergy, will continue to prohibit advertising that uses testimonials, guarantees results, claims superiority, or is "sensational or flamboyant." Edward Siegal, MD, deputy executive vice-president of the State Medical Society of New York said he expects few problems with the new ruling, since it still prohibits solicitation. Of much more concern to the Society, said Doctor Siegal, is the ruling that physicians must make records available to patients upon request. The guideline states that "failing to make available to a patient or client, upon request, copies of documents in the possession or under the control of the licensee which have been prepared for and paid for by the patient or client" shall be considered unprofessional conduct. The AMA Judicial Council's *Statement on Advertising and Solicitation* appeared in the WMJ August issue. ■

DHSS ISSUES CERTIFICATE-OF-NEED PROCEDURES

On September 1, State Division of Health Administrator Ralph Andreano mailed to all health-care providers, covered by the new certificate-of-need law, an 11-page explanation of the system and the interm criteria and standards which will be used by the Division. The memorandum was issued after consultation with the State Medical Society. Questions regarding the memorandum or the system procedures should be directed to: Michael J Phelps, Director, Bureau of Needs Review, Division of Health, 1 West Wilson Street, Room 699, Madison, Wis 53702. With the issuance of these procedures, Wisconsin became the 37th state to adopt certificate-of need legislation following enactment earlier this year in Alabama and Iowa.

SMS COMMUNICATIONS PREPARING REFERENCE KITS ON NHI

The State Medical Society's Communications Department, in conjunction with the American Medical Association, is preparing reference kits on national health insurance for use by Wisconsin high school debate teams. The National University Extension Association sponsors the debates and chose this year's debate proposition: "Resolved, that the federal government should guarantee comprehensive medical care for the citizens in the United States." The reference kits contain magazine article reprints, pamphlets, and "additional reading" lists.

PHYSICIANS! CONTACT YOUR LOCAL HEALTH COORDINATOR

At a recent meeting of the Task Force on Health Screening and Immunization, Chet Bradley, health education supervisor for the State Department of Public Instruction, informed the Task Force on how interested physicians might get involved in health education curriculum planning in their local school districts. In a model plan for health curricula entitled "Health Education for Wisconsin Schools," Bradley outlines a list of 34 competencies which public school students should obtain by graduation time from the health curriculum. This document was distributed in September to all district administrators in the state. They in turn have been instructed to convey this information to the health education coordinator in each school district. The Task Force encourages physicians to contact this health education coordinator to offer suggestions for curriculum planning in such medically related areas as personal health maintenance, sex education, and personal fitness. According to Bradley, most coordinators at the local level would greatly appreciate such input from physicians.

SMS SUPPORTS TOUGHER DRUNK DRIVING LAWS

The SMS Governmental Affairs Commission has endorsed two draft proposals of the Wisconsin Council on Alcoholism and Drug Abuse and Acting Governor Martin Schreiber, which would establish tougher standards and penalties for the Wisconsin "implied consent" and "operating while intoxicated" statutes. The OWI statute changes would establish penalties for the intoxicated use of boats and snowmobiles in addition to other motor vehicles.

SMS PRESIDENT LARSEN DOES PSAs ON DRUNK DRIVING

The Governor's Office of Highway Safety is producing three 30-second television public service advertisements dealing with drunk driving, to be aired free on all Wisconsin commercial television stations later this year and next year. Roy B Larsen, MD, Wausau, president of the State Medical Society, served as "talent" for one of the spots, produced at WTMJ-TV in Milwaukee. The two spots featured Acting Governor Martin J Schreiber. ■

the wisconsin medical journal

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Unnecessary surgery

RALPH ANDREANO'S RECENT pronouncements charging Wisconsin surgeons with performance of unnecessary surgery drew quick response from Medical Society leadership, and justifiably so. But Doctor Andreano is just one of many making that charge and the time has come to take definitive steps to ascertain whether unnecessary surgery is prevalent in Wisconsin.

First, it seems we must attempt to define unnecessary surgery, or else how can we know whether it exists? To our knowledge it has not been defined in any of the articles alleging its presence.

It is frequently stated that since there are more herniorrhaphies done in the United States than in Great Britain, the extra procedures done here therefore must be unnecessary; and if they weren't performed, great health-care-dollar savings could be realized. The fact is that in Britain fewer hernias are repaired—Is it because the English inguinal floor is stronger than the American? Is the English surgeon less likely to recommend repair of small hernias, or is it because the English patients with hernia have to wait six months to a year for their operation and tend therefore to put the operation off indefinitely? All of the foregoing could play a role in affecting the number of herniorrhaphies actually done and could explain why there are more done in the United States. But does the difference really mean that we do too many in the United States? Not necessarily.

Another example of unnecessary surgery frequently cited is the hysterectomy followed by a report from the pathologist who obviously had to reach rather far back into his vocabulary of obscurities to avoid merely stating: "normal uterus." Unfortunately, a prolapsed uterus can look quite normal to a pathologist after it has been pickled in formaldehyde, but that doesn't justify forcing the patient to keep her uterus just to satisfy the pathologist.

Herniorrhaphies and hysterectomies are just two of many operations which exemplify very well the difficulty in deciding whether an operation is necessary or not. Can an insurance clerk make a decision? Can the State Medical Examining Board? Can an administrator from the State Division of Health? None of these can possibly make that judgment. They simply are not qualified. Only one trained in surgery can or should decide whether an operation is necessary. An operation must be judged in light of the clinical situation.

That this is true has been widely recognized, and it has given birth to the "second opinion" concept which has been developed in some areas. When an elective operation is proposed, the patient is shunted to another, supposedly neutral surgeon for his stamp of approval. In case of a standoff, another opinion must be obtained. All this can be time-consuming and a nuisance. It could tend to have the same effect as the shortage of beds in Britain in keeping surgical lists shorter. Needless to say, most physicans have not been particularly enthusiastic about the idea.

Those opposed to the second opinion programs argue that they will be expensive, since the consultant must be paid, too; and that in most instances if the consulting surgeon is truly neutral, he will approve the proposed procedure anyway. They also believe that the patient's well-being may not be served in those instances where there is honest disagreement between surgeons. Certainly the patient's confidence won't be at a fever pitch as he climbs onto the surgery cart realizing that his chances of coming out ahead are viewed by two-out-of-three surgeons at best.

It is also feared that if all elective surgery proposed were to undergo the second opinion test, the system probably would bog down in paper work. Perhaps, however, it might be limited to the most troublesome operations or to certain surgeons whose practices are suspect on the basis of previous performance. That ought to be possible with minimal disturbance of the practice of surgery and the patients' equanimity if the system were properly administered.

In any event, something must be done if the question of unnecessary surgery is to be laid to rest. The second opinion method would seem to be less objectionable to surgeons, since they would ostensibly be judged by their peers. A spinoff benefit might be realized, too, since unqualified surgeons would be less likely to recommend surgery if they knew their judgment might be challenged.

Obviously if the system is to work smoothly, it requires willingness on the part of surgeons in active practice to serve on second opinion consultant panels. This job should not be relegated to retired or disabled surgeons, since their opinions might not reflect current practice. And the system would have to be administered by an agency that has jurisdiction over all physicians, be they MD or DO, family practitioner or surgical specialist. Panel members should be selected from nominees presented only by the surgical special-

Editorial Director—WAYNE J BOULANGER, MD, Milwaukee

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ties, however, since the highest standards must be applied to all, if the patients' best interests are to be served.

If we agree that unnecessary surgery might be a problem in Wisconsin, if we agree that unnecessary surgery can't be defined in such a manner that a clerk can make a decision on the basis of a check list, if we agree that a surgeon can decide whether an operation should be done only after having examined the patient, and if we agree that a second-opinion system could curb the performance of unnecessary surgery, why not give it a try with this proviso?—The program would be set up with a time limit, perhaps two years. If it fails to prove the existence of unnecessary surgery in Wisconsin, it would be dropped. All costs of the program should be documented to determine whether the system actually saves money and the report should be made public.—WJB

Inexpert witnesses

In August the Council of the State Medical Society authorized the Physicians Alliance Medical Defense Committee to support a professional liability suit with a "friend of the court" brief. This particular case involves a pathologist with no clinical experience in treating fractures who appeared as an "expert" witness in a suit involving an orthopedic situation.

This sort of action is long overdue. It is an unfair and ridiculous situation when a physician who may be an expert in one relatively isolated field, is permitted to testify as an expert across the board in totally unrelated specialties. This is as inappropriate as attorneys having to import out-of-state talent or the employment of so-called "professional witnesses," those parasites of medicine who are itinerant experts. —VSF

Medical dilemma

Your attention is called to an article in this issue *(Herniated Lumbar Disc with Leg Paralysis Associated with Jogging; Case Report,* by Doctors Guten and Harvey). Not only is this a clinical notation worthy of attention but also it illustrates one of the dilemmas of medicine, as was called to your attention some months ago.

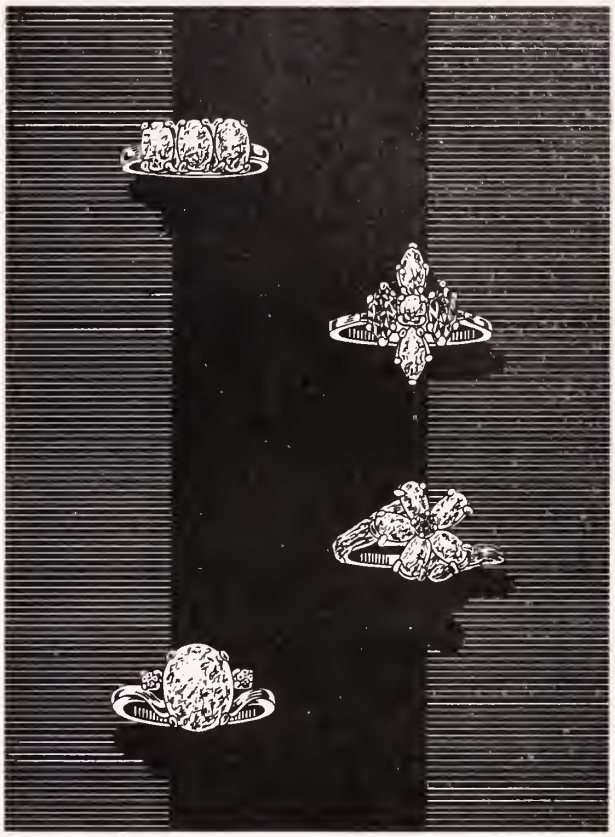
CCE (Continuing Chiropractic Education)

This display ad appeared in a Wisconsin newspaper:

NOTICE

Atkinson Chiropractic Arts Center (Doctors Park) will be closed Friday, May 13, to allow our staff to attend post graduate seminars in nutrition, to keep them abreast of the latest developements (sic) in the Science of Chiropractic.

Megavitamins here we come!—VSF ■



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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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Semantics of "cure" and "survival"

To the Editor: I do not wish to belabor the semantics of "cure" and "survival" (the term "cure" etc in LETTERS, *Wisconsin Medical Journal,* August 1977), but Doctor Mohs' preference for the term "cure" is not shared by the National Cancer Institute (Cancer data gram in NCI report, *AMNews,* Sept 5, 1977), in which the terms "survival" and "surviving" appear no less than 12 times; the term "cure" being totally absent. The term "five-year cure" may be very well understood by learned men, as Doctor Mohs states, but not by the patient whose cancer recurs the sixth year following his "five-year cure."

R W STEUBE, MD
540 Port Side Drive
Sept 17, 1977 Naples, Florida 33940

A letter to all SMS physicians

Kenosha County Medical Society President Roman Bilak, MD, recently sent a letter to KCMS members concerning nursing home patients, Medical Assistance patients, and acceptance of fee adjustments by third parties. Doctor Bilak's letter presents a model for all SMS physicians to follow.

* * *

KENOSHA COUNTY MEDICAL SOCIETY

Dear Doctor,

It has come to the attention of the Executive Committee (of the KCMS) that some physicians decline to undertake the continuing medical care of their patients when these patients enter a nursing home. While it is the privilege of the physician to refuse this type of medical supervision, it is the feeling of this committee that it would best subserve our community health needs if these physicians assumed responsibility in helping these patients obtain the services of another physician at this point. To be pointed out is the fact that "abandonment" is not an improper word to apply to this situation and is not a gentle charge.

It has come to the attention of the Executive Committee (or the KCMS) that office personnel of some physicians are neglecting or ignoring the effort and the need to return for review many obviously incorrect and low (or partial) insurance payments and are simply discounting the initial billing downward to the amount received. This of course results in less income for the physician, but of more importance may lead to an incorrectly low individual physician fee profile as is continuously being assembled by these companies and may result in lowered allowable payments in the future to a physician as the experience of these insurance companies becomes wider with respect to fees accepted by physicians (contrast this, of course, to the fee charged which should be the gauge for this, but will it?). This applies to WPS, Surgical Care, and various supplemental insurances.

Regarding physicians who refuse to accept patients on Medical Assistance (Welfare): As a member of the medical community, in all fairness to our colleagues and to our profession, our moral obligation is to assume care of all segments of our population, disregarding the renumerative factor. This responsibility should be shared by all of us collectively and individually.

Sincerely,
KENOSHA COUNTY MEDICAL
EXECUTIVE COMMITTEE

Physician Reimbursement

To President Larsen: On behalf of the Advisory Committee on National Health Insurance Issues, I want to thank you for joining us in Marshfield to discuss the issue of physician reimbursement. The Committee members found your presentation and the entire panel discussion very interesting. I am sorry that we could not schedule more time for that panel—the Committee members would have liked to pursue the issue much more fully. Again, thank you for being with us.

JULIUS B RICHMOND, MD
Assistant Secretary for Health
Department of Health, Education, and Welfare
August 8, 1977 Washington, DC 20201 ■

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin.

Wisconsin leaders talk about health care

REPRESENTATIVE JOSEPH CZERWINSKI, a Milwaukee Democrat, is chairman of the Assembly Health and Social Services Committee which considers the key legislation affecting physicians and the delivery of health care in Wisconsin. —A project of the SMS Communications Department

Q. When doctors look at the Legislature, the political process, they think of one thing and that's regulation of their profession. They think of certificate-of-need, they think of administrative rules such as prior authorization, and for that reason many don't really like the whole process at all. Do you see more regulation of doctors by this state in coming years?

A. Well, I think it's unfortunate that the first time the Legislature became involved in the medical community (certificate-of-need) that that involvement had the impetus of control, or the effort of regulation, or certainly a very broad sense it wouldn't take a hell of a lot of imagination, that it wasn't a very 'even' kind of relationship. We were seeking one thing and they, of course, their natural response of trying to repel, as any citizen I think does not enjoy regulation.

I think the future is a little bit more exciting. What we have attempted to do and will do throughout the next few years is to have the Legislature gain some experience (in the medical area). One of the ways in which government can do this, unfortunately, is through the regulatory process. Legislators are not accustomed to doing other things. Essentially they tax and regulate and through that experience, hopefully, they acquire greater insight. At the same time I would hope that the medical community will develop some insight that government is not trying to be bizarre, it is not trying to place a wedge between the physician and his patients.

But there are some public policy measures that have to be extended. I am hoping that we'll get over this rather mundane period of simply developing the regulatory statutes and start opening up the system for basic elements such as preventive care, letting the throes of the economic system start dictating a little bit more. But we had to, I think, because of the increasing amount of public revenues going into the health-care system. We needed a hiatus, we needed a pause, we had to slow down the system, and we had to use a system which government could understand to better the health-care community. So I would hope that decisions in the future will be a litlle bit more imaginative as things develop into more of a partnership.

JOSEPH CZERWINSKI

"The future is a little bit more exciting. What we . . . will do throughout the next few years is to have the Legislature gain some experience (in the medical area) . . . One of the ways . . . unfortunately, is through the regulatory process."

Q. Do you think there is any way that this State Legislature can work to hold down the cost of health care, when basically you've got a situation where the consumer doesn't determine how much he is going to spend; and when the bill comes in, its paid by a third party? Is there any way to hold down rising health-care costs?

A. That's the reason why we needed the controlling mechanisms, first of all, to approach those great cost centers. And if you look back, the impetus wasn't a high priority on physicians and physicians' offices, but to approach the high cost centers; *ie,* the hospitals and the duplicatory equipment that may be

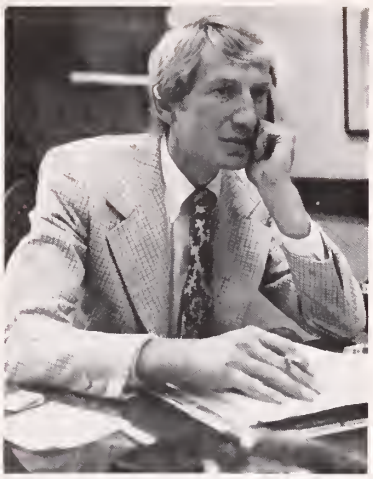
found in physicians' offices, but most likely are not.

And now the next step is much, much more difficult and needs much more imagination. I think that in the first instances there are some traditional pathways that the state government can take to encourage a greater appreciation of the health-care dollar by the consumer.

First of all, I think all consumers should receive a billing of exactly what the services were and be encouraged to contact a third party if in fact those services were not provided. And those billings should be done in a simple way that people can understand.

Secondly, I think that the area of emergency care is starting to become a great cost item where hospitals are finding they don't have to depend upon physicians for inpatients. We have a number of hospitals throughout the state that produce 50 percent of their own inpatients. That's a change in relationship between hospitals and physicians, and one in which I think state government could get involved. So I could see the state government placing a mandatory co-payment for all emergency services because they reflect the worst in thoughtful medical care by the patient. Emergency services just cost a great deal of money. They benefit the fellow or woman, or the child, or the family who haphazardly goes about their business and does not organize their health-care program.

Thirdly, I think the greatest reservoir of health would be through the insurance mechanisms. The State does regulate insurance companies. I think they ought to find ways in which, if not to force but to encourage that all insurance companies partially pay or certainly recognize, and have a certain payment for physician visits and for other kinds of personal health-care programs.



"All consumers should receive a billing of exactly what the (health-care) services were and be encouraged to contact a third party if in fact those services were not provided . . . emergency care is starting to become a great cost item . . . greatest reservoir of health would be through the insurance mechanisms . . . health education . . . spend a great deal of time depending on . . . but, not being a traditional state responsibility, is one that we need the involvement of the medical community."

And finally, all those things are without speaking about health education in which we have to spend a great deal of time depending upon. But just as we have to do that, so does the medical community. Education being a state responsibility, I recognize it all. But at the same time health education, not being a traditional state responsibility, is one that we need the involvement of the medical community. Those are things which I think can improve health care and those are more imaginative, exciting, and I think will have to be dealt with on a partial basis.

Q. When we interviewed Ralph Andreano, we asked him if he thought Medicaid benefits in this state would become more inclusive and he replied, "I don't know what more we could offer in this state; I'm thinking the other way around." What do you perceive as the future of Medicaid? Do you think it will ever start cutting benefits? How do you hold down the cost of that program?

A. Well, first of all, I'll have to recognize the overwhelming cost, nearly 70 percent of it is nursing home and long-term care. In that regard there are a number of things we ought to encourage, but again we can't do that without a very critical and energetic and totally involved medical community. It's impossible for state government to make decisions about who should and who should not be in nursing homes; and I think its a relationship between patient and doctor that doctors don't want to lose. But physicians may very well lose it if they don't treat each one of those decisions and each one of those patients very, very seriously and understand what each decision means. So with regard to long-term portions of the Medicaid program, the Medical Society and the medical community ought to teach doctors the economic ramifications of their decision of signing a patient off into a nursing home. If they understand that, they'll treat that decision much more seriously.

Home health care, of course, is the alternative to which we are looking. In terms of what I think Ralph Andreano was talking about (that 30 percent) I think we have, at least nationwide, a very benevolent program. I think the greatest step forward we can do is to separate the Medicaid

program from the welfare program. We ought not suggest that anyone who is on welfare is automatically on Medicaid because it intertwines both, and one system is not made for the same kind of criteria as the other system. We ought to force the Medicaid program into an insurance policy fora, or in fact the Insurance Commissioner ought to have responsibility for it.

Czerwinski and Thomas Loftus, Sun Prairie Democrat, who is vice-chairman of the Assembly H&SS Committee

How do you hold down the cost of the Medicaid program? ". . . I'll have to recognize the overwhelming cost, nearly 70 percent of it is nursing home and long-term care . . . there are a number of things we ought to encourage, but again we can't do that without a very critical and energetic and totally involved medical community . . . the Medical Society and the medical community ought to teach doctors the economic ramifications of their decision of signing a patient off into a nursing home . . . Home health care . . . is the alternative to which we are looking."

I think we are going to see in the future where there is going to have to be, as there is with any other person and any other first-dollar relationship, some way in which to force patients to recognize the cost of what they are seeking, whether that's a co-payment system, whether that's a subsidy system, whether that's a voucher system or a pay-back at the end of the year for those services that they don't use. Those things are being studied right now, and I suspect in the January session we'll have such a bill. So I think in terms of benefits, it's a good deal. I think it ought to be moved away from the welfare system; we ought to adjust that first-party avenue.

And finally, we ought to make certain that people don't stay on welfare or seek welfare simply for the purposes of gaining Medicaid benefits. If there are a number of those kinds of people (there has been a wide number of suggestions that there are), then that's all the more reason why we ought to have that as an insurance mechanism rather than a welfare mechanism.

Q. In all of these things we are talking about here, what do you view as the role of the State Medical Society and the Physicians Alliance Division within the Society; and secondly, how would you compare the Society's efforts these days with a few years ago?

A. Well, I can't speak highly enough for the way the State Medical Society and the Physicians Alliance have changed their tone toward the Legislature. I think that in the past it simply has been a painful experience and one that they felt they had to go to to stop legislation and seldom supported and never initiated legislation. I think that's changed, and I have to extend all best respect for that. I think what's necessary, though, in the future, along with that general change of attitude, is for the Medical Society and its Physicians Alliance to help us identify those gaps in the system: Who falls through the system? Why do they fall through the system? Do we, can we, in fact, drastically increase the protections of our programs that exist now and in what ways?

Secondly, I think they have to help us recognize where we have maldistribution problems and how we can bend the educational system to help us approach those programs. They have to, in fact, help us understand "the doc": What's he looking for? How many patients does he need? Take an example, the State traditionally acts as an equalizer; that's why we have state aid formulas—that the kid in Ashland County gets the same kind of education as the kid in Milwaukee County even though Ashland County doesn't have a significant property tax base. We extend that concept through a number of other services, mental health services, any number of things. If we have a problem with distribution of doctors, the government's first blush is: How do we force them out? Maybe we incarcerate them! A better idea would be to understand what the doctor is looking for, again understanding what that young doctor is looking for. And that can only really come from the profession itself; we can send out all the questionnaires we want, but we don't have that kind of insight. There's no question in my mind, our policy decisions would be wrong. The Medical Society also can, as a matter of continuing education or whatever mechanism, deal with one thing that's lacking throughout a doc-

"We are going to see in the future . . . some way in which to force patients to recognize the cost of what they are seeking, whether that's a co-payment system, whether that's a subsidy system, whether that's a voucher system or a pay-back at the end of the year for those services that they don't use. Those things are being studied right now."

tor's education, and through internship, through residency, and through preceptorship, and throughout, and that is medical economics. They don't understand the ramifications of asking for that extra task, they don't understand the ramifications of prescribing that a person's going to a nursing home; they don't understand the economic ramifications of referring to a psychiatrist. Those are important things. I know doctors are terribly busy and I think many of their decisions are knee-jerk ones; I'm not saying that in a critical sense because I think a lot of legislators and a lot of other people do the same thing. If you don't have the other side of the coin, you're not going to make legitimate decisions. We have problems in geriatrics and we have problems in specialized diseases that are causing a great deal of personal problems, and those personal problems sooner or later become public problems. How do we encourage home health care for hemodialysis, for hemophiliacs? The next question is how do we develop a totally encompassing screening and immunization program for all young children from birth, prenatal, well-baby, all the way through? When can the system take a low profile? When does it come back up again? It's impossible to believe that we have those kinds of resources in state government, but you have to know that we have those responsibilities. I think those are the kinds of things that the Medical Society can help solve. ■

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Philosophical impetus for professional liability legislative program

THE PHYSICIANS ALLIANCE Division was charged with various objectives by the SMS House of Delegates when organized in 1975. During the past two years, the Alliance through its special committees and related activities has studied the overall medical liability situation and its impact on physicians and society. Two such groups that relate directly to the questions involved in medical liability are the Ad Hoc Committee on Professional Liability and the Medical Defense Committee. The efforts of the Alliance have culminated in a series of Legislative drafts which are being considered by the 1977-79 Legislature.

VISTE

One of the goals assigned to the new Physicians Alliance was the protection of the physician-patient relationship in the delivery of health care. This necessary adjunct to effective medical care had been seriously eroded by a number of factors in 1975, and most especially by a growing climate of suspicion and lack of communication between patient and physician.

Symptoms of this unhealthy adversary relationship have been a highly increased number of malpractice suits, the growth of defensive medicine, and a dampening effect on innovative procedures and techniques. Obviously, this atmosphere is not conducive to the delivery of quality health care.

The Chairman of the Alliance's Ad Hoc Committee on Professional Liability also served on the special legislative committee on malpractice, formed by the State Legislature in 1975. This group was composed of representatives from the insurance industry, attorneys, public members, and medical providers in addition to legislators. The work of this group resulted in two bills that are being considered by the current Legislature.

The State Medical Society and the Physicians Alliance support this special committee's work and the two bill drafts that resulted from their endeavors. One is basically a "housekeeping bill," but does offer certain advantages for physicians in Wisconsin, such as allowing the Society to self-insure, if this becomes desirable; and, to shorten the time from 60 days to 10 days for notice of cancellation or nonrenewal in the State Plan.

One of the Alliance-endorsed bills would discourage frivolous or unfounded medical liability suits and applies to all tort liability actions. Enactment of this bill should reduce the number of suits and eliminate spurious actions, thereby easing the tensions between physician and patient. For a number of reasons, the general public has come to expect perfection in the medical profession. However, an untoward result should be viewed as just that rather than calling for a search for a culprit. The "frivolous suits bill" would impact on these "fishing expeditions."

Another charge given to the Alliance was the advancement of the socio-economic interests of physicians. A Medical Society bill that addresses itself to this area of concern is a bill that would prevent duplicate payments to patients for the same item of liability. Medical liability insurance premiums have increased dramatically over the last several years and this bill has been conceived to help stem that upward tide as well as to restore a semblance of balance and fairness in the present system of the delivery of health care. If it is true that our society can no longer afford to "indulge" a physician's right to veto an insurance settlement of an alleged malpractice claim (as is currently law) for reasons of economics, then it must likewise be true

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that society can no longer afford to pay duplicate and even triplicate amounts for one liability.

The "long tail" used in computing liability insurance premiums would be reduced by a Society-endorsed bill (this is the second bill that emerged as a result of the special legislative committee on malpractice) to lower the statute of limitations for minors. This should not only reduce liability insurance premiums but also would hold medicine accountable for a more realistic time-span and help prevent today's medical care from being judged by tomorrow's standards.

In order to provide some realistic choices to physicians and patients, a voluntary binding arbitration draft has been proposed by the Physicians Alliance. In our continuing study of the medical liability problem, we keep hearing that the present tort system needs to be changed in order to effect long-lasting positive results. The binding arbitration draft provides an alternative to the tort system for resolving medical liability claims. Often the most experienced, well-trained physician who tackles difficult problems in medicine is rendered virtually uninsurable by exposure to law suit under our present tort system and this proposal offers a possible alternative.

The Alliance has matured in its two years of existence. We have come to understand more about the realities of the political matrix in which we live. Several proposals for legislative changes in the professional liability statutes have therefore been altered or not pursued due to these political realities. However, we continue to study medical liability and are striving through legislation, political activity, and physician involvement at the county and state levels to insure the continuance of medical leadership in health-care policy development and to create, or recreate where necessary, a positive climate to practice our profession with medical professional liability that is equitable for all.

Another correlative activity has been the Medical Defense Committee which has worked diligently with legal counsel in reviewing settled professional liability suits of our fellow physicians where the possibility of countersuit may exist. The Committee also has been investigating other options and means of resolving professional liability disputes for physicians. This reviewing service can provide a "peer-sounding board" for Society members who request objective analysis of their cases.

If you have any questions about the Society's professional liability legislative program or the philosophy backing this program, please call the Physicians Alliance office at SMS headquarters: 608/257-6781.

—KENNETH M VISTE JR, MD
Oshkosh ■

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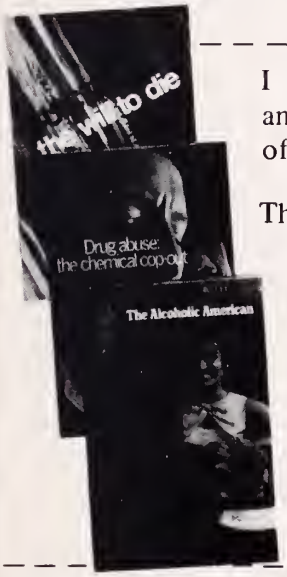

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Sour grapes over saccharin

THE RECENT PROPOSED ban by the FDA on the use of saccharin as a sweetening agent is not the first time it has been tried. In 1912 a similar attempt was made, but the president, Teddy Roosevelt, was diabetic and overruled the attempt.

The present ban has stirred a great deal of controversy concerning the need for a regulation like the Delaney amendment. Should the government have the power to ban any material which has been shown to be carcinogenic or should it be allowed to use discretion in weighing anticipated risk of cancer against the social or medical benefits of using the substance?

In 1886 studies showed no adverse effects when people were given single doses up to 5 gm. No ill effects were seen in diabetic patients who received 5 gm a day for five months in 1888. Animal toxicology studies which were done from 1920-1950 didn't show any adverse effects, and several more recent studies have been inconclusive or inadequate in design.

Dr G T Bryan and coworkers at the University of Wisconsin in 1970 implanted saccharin in cholesterol pellets into female mice. Most of the saccharin had eluted from the pellets in 1.5 days, so the exposure was very brief; however, the treated animals had a 47-52% incidence of bladder cancer after 13 months compared to 12-13% in control animals.

About the same time the FDA did a study in which saccharin was fed to rats after weaning. They were then bred and their offspring fed saccharin for their entire lifetimes. Male rats had a 30% and females a 6% incidence of bladder tumors compared to 4% for male and 0% for female controls. Similar results were obtained at WARF (Wisconsin Alumni Research Foundation) in Madison, Wisconsin. However the saccharin used in both experiments was probably contaminated with o-toluenesulfonamide, a known bladder carcinogen for the rat. It also is a contaminant of some commercially available saccharin.

A Canadian study in 1974 showed that saccharin was definitely carcinogenic in rats and that the effect was not due to o-toluenesulfonamide or its tendency to induce bladder stones at high doses. Second generation rats fed saccharin had a 14% (12% male and 2% female) incidence of bladder cancer compared to 7% (no female) during the first generation.

A study was done in 1975 to see if saccharin acted as a co-carcinogen in rats which had been treated with an irritating, but non-carcinogenic dose of N-methyl-N-nitrosourea. Alone saccharin had little effect, but together 58% of the rats developed bladder cancer in eight weeks.

In 1975 and 1976 Kessler at Johns Hopkins and Armstrong and Doll in England failed to show any excess of bladder cancer in patients who used saccharin, but problems with experiment design raised some doubts as to their significance. Recently Wynder and Goldsmith found no association between bladder cancer and saccharin, but their data were only incidentally assembled with information on smoking and industrial exposure.

At the Society for Occupational and Environmental Health meeting in Washington, DC, in September 1977, Dr A B Miller of the National Cancer Institute of Canada reported on a retrospective case-control study of over 600 people with bladder cancer and appropriate controls. It showed a positive dose and duration related correlation between saccharin use and bladder cancer in human males. There was approximately a 60% increase in bladder cancer risk in men. Fewer females than males develop bladder cancer, and they didn't appear to be at increased risk due to artificial sweeteners. The incidence was higher in British Columbia than in eastern Canada. About 7% of bladder cancers in the general population and a third of those in diabetics could be attributed to use of artificial sweeteners.

Although saccharin has been used for over 80 years, it only has been used in large amounts for the past 15 to 20 years. Dr Irving Selikoff, Director of the Environmental Science Laboratory at Mt Sinai School of Medicine, suggests that this is not a long enough time for some types of human cancer to develop. And if the effects of saccharin are accentuated in second generation offspring as in the animal studies, it is too soon for these to have been observed in humans; besides, results of experiments in rats may not be applicable to humans. In addition, it has been used in such large quantities in so many ways as a food and drug additive that it would be difficult, if not impossible, to select proper controls.

Doctor Bryan believes that the data from the epidemiological and animal studies are as strong as those that were used to implicate β-naphthylamine and cigarette smoking as causes of bladder cancer and that the use of saccharin should be restricted. We must determine if there are really benefits to be derived from using saccharin. Does it help with weight control or prevent dental caries? If the benefits are merely economic for the industries which manufacture and use saccharin, should we permit our eating habits to be altered in ways that pose a potential danger when a little self control and use of good nutritional practices would be preferable?

Diabetics are a very select group who comprise about 5% of the population. If they were permitted to selectively choose to use artificial sweeteners knowing the potential dangers and possible benefits, there would be no need to subject the other 95% of the population to the risk of developing bladder cancer.

Because the studies that have been done do not indicate any immediate hazard to public health, Sherwin Gardner, Acting Commissioner of the FDA, says that they did not consider the recall of existing products to be necessary. Since 1972 the FDA has been encouraging manufacturers to discontinue the use of saccharin as soon as possible in order to prevent its general use by consumers and to prevent an increase in its use.

At present sale of no other sweetener is permitted. Cyclamates were banned in 1970. Data on another sweetener, Aspartame, are being reviewed. Although the saccharin ban has not been imposed yet, use of saccharin may be avoided because all products containing saccharin must list it on the label.

—DOROTHY J BUCHANAN-DAVIDSON, PhD
Science Writer
Wisconsin Clinical Cancer Center

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

CANCER COLUMN

PREPARED AND SUPPORTED BY
WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH
STATE MEDICAL SOCIETY OF WISCONSIN
AND ITS
COMMITTEE ON CANCER

Colon-Rectal Cancer Programs

. . . will be held at Chippewa Falls and Woodruff on November 16 and at Monroe on November 30. For further information see the YELLOW PAGES of this issue. ■

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MEDICAL HISTORY

William Beaumont, MD: A Wisconsin Legacy

Dean M Connors, MD, Madison, Wisconsin

William Beaumont's career as a practicing physician (1812-1853) extended well beyond the years of his active interest in gastric physiology (1825-1833). Many writers have pictured Beaumont as a competent but unexceptional physician who, when fortune presented him with "that old, fistulous Alexis" responded by doing what any average physician would have done—making the obvious observations and few simple experiments. This picture does not fit well with the knowledge that there had been at least eight published cases of acquired external gastric fistula prior to St Martin, and none of these individuals had been subject to any kind of physiologic observation.[1] Moreover, today anyone reading Beaumont's classic "Experiments and Observations of the Gastric Juice and the Physiology of Digestion"[2] will be immediately impressed by the sheer quality of the work, clearly the product of a meticulous, truly scientific mind. Beaumont's preparation for this major work was anchored in the solid background of his medical training and in his original and authoritative medical practice. Beaumont's contribution to medicine of the first half of the last century was not limited to his important discoveries in gastric physiology.

William Beaumont first published his case report of Alexis St Martin's injury and recovery in 1825 in the "Medical Recorder," an early journal in the United States. The results of his first four experiments were published in the same journal in 1827. All this work was done, and both papers written while Beaumont was stationed at Fort Mackinac in Michigan. When Beaumont was transferred to Fort Howard in Green Bay in June 1826, St Martin returned to his home in French Canada, apparently tired of the embarrassment resulting from his unique anatomical condition. During the two years Beaumont was stationed at Fort Howard, he spent a good part of his time trying to locate the recalcitrant St Martin and then to persuade him to return for more experiments. Through the efforts of officials of the American Fur Company, these attempts were ultimately successful and Beaumont was able to perform 56 of the key experiments in the series on St Martin from December 6, 1829 to April 9, 1831 while he was stationed at Fort Crawford in Prairie du Chien. Later 116 additional experiments were performed in Washington, DC and in New York City, along with a further group of 62 experiments in Plattsburgh, NY in 1833. These later studies confirmed and extended the initial observations made in Wisconsin.

At a time when there were fewer than a dozen medical schools in the country, William Beaumont's medical training, like most of his fellow practitioners of the period, consisted of an apprenticeship to an older practitioner, "reading" medicine. Towards the end of his two-year training period and for nearly 20 years afterward, Beaumont kept an informal set of notebooks, containing comments on his medical reading, a variety of prescriptions, case reports of special interest to him, and a number of quotations and references to various literary and philosophical texts he was reading at the time. Two of the early notebooks have been edited by Genevieve Miller and published as "William Beaumont's Formative Years,"[3] which provide us with a great deal of information about Beaumont's reading in those early years. According to Garrison in his "Introduction to the History of Medicine,"[4]

> "the favorite textbooks of the period were Albinus, Cowper, Cheselden, Monro, and Winslow in anatomy, Haller's First Lines of Physiology, Boerhaave and van Swieten on internal medicine, Heister's surgery, Smellie's Midwifery, and of course, Sydenham, Huxham, Pott and other well-known authors . . . . . there was very little study of physiology or pathology . . . .".

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Reprint requests to: Dean M Connors, MD, 707 South Mills St, Madison, Wis 53715.

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Beaumont's early notebooks contain quotations from Van Haller, Huxham, Van Swieten and Sydenham. Additionally there is material referring to William Saunder's treatise on the liver, Townsend's Elements of Therapeutics, Cullen's First Lines on the Practice of Physick, Thatcher's Dispensary and Robert John Thornton's Philosophy of Medicine. Interestingly enough, there also are many quotations from John Brown's Elements of Medicine. John Brown in Edinburg developed a highly controversial theory of disease, and a system of therapeutics based on the use of large doses of alcohol, opium or both in combination. The controversy between Brunonian and non-Brunonian theorists was rampant in late eighteenth century Europe, at one point reaching such a level of intensity that a confrontation between medical students at the University of Gottingren required a troop of cavalry to end a two-day period of violence. Benjamin Rush in America also developed an equally improbable theory of disease, but preferred large doses of calomel and heroic bleeding to opium and alcohol. There is no evidence that Doctor Beaumont actually subscribed to either Rush's or Brown's extremes in therapeutics, in fact, as Brodman has pointed out,[5] Beaumont was conservative and entirely contemporary in his mode of treatment.

In her much-quoted article: "Dr. William Beaumont: His Life in Mackinac and Wisconsin: 1820-1834,"[6] Deborah Beaumont Martin cites a list of books in the Fort Howard medical library of 1827 as described in the Inspector General's report of that year:

> "Bell on venerial 7 copies, Cooper's surgery 3, Dispensatory 2, Dorsey 2, Dr. Rush 8, Sydenham 1, Dr. Rush and Prindle 1, Dr. and Surgeon's Vade Mecum 8, Thomas Practice 4."

The Inspector General comments that "the number of volumes appears well enough, but furnishes very little variety." In the Beaumont manuscript collection of the library of the Washington University School of Medicine there is a lengthy handwritten analysis of several articles by European physiologists including Leuret, Lassaigne and Gmelin which had been translated and published in "The Edinburgh Medical and Surgical Journal of 1827." The same manuscript collection also includes a neatly written "synoptical index" or card index of articles in the literature of the time on gastric physiology, which Beaumont prepared in 1833 at Washington, DC. This material relating to contemporary information on gastric physiology was eventually incorporated into the review of literature appearing in the "Experiments and Observations." It is abundantly clear from these documents that Beaumont had an unusually extensive background in general and medical literature and was capable of conducting a sophisticated literature review in the most advanced medical libraries of the time.

In the two published notebooks and in the later manuscript notes as well,[7] there are interspersed a number of medical case reports. The medical history of Alexis St Martin first appears as one of this series. In all, there are 25 cases presented in sufficient detail to allow comment. Of the 25, eight terminated fatally. Beaumont's case studies include postmortem finding in four of these eight cases. It should be kept in mind that autopsies were probably not uncommon in the medical schools of the time, but not often done in rural practice. Reports of post-mortem examinations in any case are quite rare. The first textbook of pathologic anatomy written in the United States did not appear until 1829, and the modern systematic autopsy with its various weights and measures, as well as the fundamental work in pathologic anatomy of Laennec, Virchow and Rokitansky were still in the future.

Beaumont became interested in vaccination as a method of preventing smallpox while in Green Bay in 1827. Correspondence with Dr Joseph Lovell, the Army's Surgeon General and a lifetime friend of Beaumont's, indicates that he was able to obtain living virus from Lovell to inoculate a large number of Green Bay inhabitants including many of the local Indian population. At the time, smallpox was so common as to be taken for granted. During the first half of the nineteenth century, the propriety of vaccination remained a topic of debate, and vaccination in the United States did not become popular until after the Civil War.[8]

Malaria, known as intermittent fever or ague, was an ubiquitous, debilitating illness of frontier life in the Upper Mississippi region. The Beaumont manuscripts include a series of notes entitled "History of the Intermittent Fever as it Prevailed at Prairie du Chien in the Summer and Fall of 1830," in which considerable insight into the causative factors associated with malaria is presented. Although quinine at the time was

exhorbitantly expensive and did not come into general use in the treatment of malaria in the United States until after the 1840s, the hospital dispensatory records indicate that Beaumont stocked quinine at Fort Crawford and used it regularly in the treatment of malaria, in addition to the other usual nonspecific modalities for fever current at the time.[9]

Cholera reached the United States in 1832 for the first time, just about the same time the Black Hawk rebellion occurred in Wisconsin. Both Deborah Martin and Doctor Myer in their biographies indicate Beaumont was active in the cholera epidemic and in the Indian rebellion. Miss Martin says:

> "The Black Hawk war was also an event in Dr. Beaumont's Wisconsin life, in which he was an active participant, not as a military commander, but as chief director in the 'cholera campaign' as the Indian raid in years following was named in army circles. The disease was brought west by the troops under General Scott, who was detailed to distant Wisconsin in order to quell the Winnebago uprising. All through the summer of 1832 the cholera raged through the villages and garrisons along the Mississippi and Green Bay. Dr. Beaumont was then stationed at Fort Crawford and did wonderful service in caring for the terrified inhabitants and in sending to Fort Howard and other badly stricken districts formulas and methods of treatment."

Jesse Myer is also quite specific:

> "Dr. Beaumont's detention at Fort Crawford gave him a wide experience in two campaigns—that against the Indians and that against the cholera . . . his experience with the disease was evidently quite large, and he manifested considerable interest in the study of it. In an undated manuscript, Beaumont expresses a unique view of the cause of cholera: 'The Greater proportional numbers of deaths in the cholera epidemics are, in my opinion, caused more by fright and presentiment of death than from the fatal tendency of violence of the disease'."

In all probability Beaumont's experience with cholera was more likely obtained in St Louis some years later. In his book on the history of Prairie du Chien, Dr Peter Scanlan makes this unusually waspish statement:[10]

> "Dr. Beaumont stayed in his cozy home at the rock hospital all the time during the war; neither did he see any cholera cases at Prairie du Chien."

Doctor Scanlan points out that General Scott did not arrive at Prairie du Chien until well after the massacre of Bad Axe which ended the Black Hawk rebellion. Furthermore, study of the hospital records at Fort Crawford by Doctor Scanlan showed that there were no cases of cholera reported until late in August 1832. By that time, Beaumont had already departed Fort Crawford for assignment to Washington. Despite these differences on the part of the biographers, there is no question that Beaumont took great interest in these various epidemic diseases, and in some instances was in advance of his time in theory, and in the matter of treatment and prevention.

There is much evidence that William Beaumont enjoyed an excellent reputation as a practicing physician throughout his entire life. The Reverend Jedidiah Morse, father of Samuel F B Morse, inventor of the telegraph, was traveling on a government inspection tour of Indian conditions in the west and arrived at Mackinac on the same boat with Beaumont. Becoming ill on the trip, Morse wrote in his report of the early 1820s:[11]

> "In the feeble state of my health, I felt it to be a peculiar smile of Providence, to be favored, as we were, from Canandaigua to Mackinaw, and during our stay at the latter place with the company of Dr. Beaumont, Post Surgeon of the 3rd Regiment of the U.S. Army, a gentleman of much skill in his profession, and of most amiable and kind dispositions. To him, by means of his medical prescriptions and attentions, I feel indebted, under Providence, for the degree of health, which enabled me to fulfill my duties to the Government, probably even for my life."

General Albert G Ellis in his recollections,[12] also reports in a most highly laudatory fashion on his treatment by Doctor Beaumont and his assistant while at Mackinaw, after relapsing "with lake fever" while traveling from Detroit in 1821. In the memoirs of John H Fonda,[13] an early Prairie du Chien pioneer, there is the story of a young army officer, Lieutenant Gale, who becomes deranged from fear of the Indians while on a military mission on the Chippewa River. Lieutenant Gale became lost, wandered for three days in the freezing weather until found, and had his feet frozen to the knees. He was eventually brought to Fort Crawford and placed under the care of Doctor Beaumont, after which Lieutenant Gale "enjoyed perfect recovery." Juliette Kinzie in "Wau-Bun,"[14] her charming story about life in early Fort Winnebago, tells about her husband taking his mother down the Wisconsin River from Portage to Prairie du Chien in the late fall of 1831 "for the benefit of medical advice from Dr. Beaumont." The extreme difficulty of the trip and an early ice-over of the river on the return suggests the importance of the consultation at a time where there were other physicians in the area. Deborah

Beaumont Martin's biography describes Beaumont's practice in Green Bay this way:

> "His reputation among the French inhabitants for skill and kindly dealing was widespread. For many years after he left Fort Howard tales of 'Le bon docteur who mak' de meracle' were rife among the voyageurs of La Baye."

Beaumont seemed able to quickly establish a busy practice whenever he went, and indications are his St Louis practice was not only a large one, but involved a considerable amount of consultation work as well. Indeed, in both the two notorious liability suits Beaumont became involved in while at St Louis, he had acted as consultant, not the primary physician. According to Doctor Myer:

> "The Doctor's professional standing among laymen is best evidenced by the fact that within a year after opening his office he had a very large and lucrative practice, his standing in the profession was shown not only by a large consultation practice, but also by the action taken about this time offering him the chair of surgery in the first medical department established west of the Mississippi." In 1840 he was elected President of the fledgling State Medical Society of Missouri.

There can be little doubt that Beaumont was an outstanding physician of his time, and was a leader among the medical practitioners of the early west.

The State Medical Society of Wisconsin, for its Museum of Medical Progress, produced a souvenir booklet: "William Beaumont M.D.; Physiologist," a reprint from the biographical "Little Journeys to the Homes of Great Physicians."[15] The author notes that maturity coming early to Beaumont permitted him to leave his family home at the early age of 17, which the author feels was because Beaumont "must have been blessed with a sound set of endocrines." The author of this booklet goes on to comment on Beaumont's taking up another business on the side during the slow times of his early practice in Plattsburgh, New York:

> "He soon discovered however, that practicing medicine and owning a business just do not mix. One cannot do both successfully. . . . if any good came to the members of the medical profession from the great business earthquake of 1929 it came through proving to them that they could not keep one eye on their patients and the other on market quotations. It just cannot be done. Imagine William Osler taking time to study stock market quotations over his morning coffee; Louis Pasteur putting in time trying to unravel a monthly balance sheet; Sir James Lister worrying about a payroll. Trying to keep two irons in the fire, one professional, the other business, has ruined what otherwise would have been fine creative medical minds. If you serve medicine faithfully medicine will take care of you."

The author of these comments is none other than C V Mosby MD, founder and owner of the giant C V Mosby publishing company of St Louis. Mosby, however, did not trust his own promises and early abandoned his medical practice for book publishing.

Beaumont on the other hand not only continued his lively medical practice until the time of his death, but became deeply involved in various business ventures, particularly speculative land investments. His later correspondence abounds with documents relating to his land purchases, most of them in Wisconsin.[16] In Green Bay as his land agents he used the early settler Daniel Whitney and later Morgan L Martin. In Prairie du Chien he used Hercules Dousman. His son "Buddy," Israel Green Beaumont, also later acted as his land agent in Wisconsin. A document in the Beaumont file in the Wisconsin Historical Society's Library in Madison, written in Beaumont's own hand and dated June 9, 1851, lists Beaumont's land holdings in Wisconsin and assigns "power of attorney and general agency to my son Israel Green Beaumont to take charge, management and disposal of the foregoing tracts of land." The lands catalogued and described in this manuscript are:

1. A town tract in Navarino. The boundaries are described in the document and a note made by Beaumont that the title was unencumbered to date.
2. Two town tracts in Fond du Lac, on which a saw mill had been built. In this entry Beaumont comments: "Suppose H. L. Dousman has the patent."
3. At Prairie du Bay, an early land development on the Wisconsin River between Blue River and Boscobel, an undivided one-eighth of a tract totalling 200 acres. Beaumont writes that the title to this property is under litigation, and he has authorized Governor Dewey to act as his agent and attorney in the case.
4. A part interest in an undeveloped tract of 280 acres near Belmont in LaFayette County.
5. An undivided half with Hercules Dousman of another 280 acre tract near Patch Grove in Grant County on the "West Branch of the Grant River," along with another unspecified interest in a nearby 400 acre tract.

The town lot at Navarino is of special interest. Beaumont had purchased the land in 1834 from Daniel Whitney. Whitney had made what was considered to be a wild speculation by purchasing uninhabited marshland across the Fox River from Fort Howard, north of the

settled part of that area then known as Astor. The settlements of Astor and Navarino eventually consolidated to form the town of Green Bay, and the Beaumont property came to be situated in what is now the heart of downtown Green Bay. On this land Beaumont's son Israel operated the "Washington House" Hotel. After William Beaumont's death in 1853, his widow moved back to Green Bay. In the early 1860s "Mrs. Deborah Beaumont and her son Israel Green Beaumont fitted out the Beaumont House. . . . which gained a wide reputation as one of the best hosteleries in the West." Over the years the hotel passed into other hands, but survived into the middle of this century. It has since been torn down and another hotel built on the site, known today as the "Beaumont Inn."

Beaumont had four chilren. Sarah, born in 1822 at Fort Mackinac, died in 1914 in St Louis. William born in 1824, also at Fort Mackinac, died in infancy. Lucretia was born while the Beaumonts were stationed at Fort Howard in 1829, and died in St Louis in 1850. Israel Green was born at Fort Crawford in Prairie du Chien in 1829 and died in Green Bay in 1901. Israel married Julia Pelton of Green Bay by whom he had six children. Israel and Julia's children Douglas and William died early and were never married. Julia Beaumont married William Cummings and moved to California. Ethan Allen married and lived in DePere, leaving two daughters. May and her sister Sophia Beaumont, granddaughters of William Beaumont, remained spinsters in Green Bay all of their lives.

In 1835 William Beaumont returned to Wisconsin on an inspection tour of various forts and garrisons of the west. During the trip he visited Green Bay in company with his wife and their 16-year-old niece, Elizabeth Smith, the daughter of Mrs Beaumont's recently widowed sister. Two years later Elizabeth Smith returned to Green Bay to become the wife of Morgan L Martin, a rising young attorney and businessman of the area. Morgan Martin became famous in early Wisconsin history as the promoter of the ill-fated Fox-Wisconsin waterway and as one of the primary authors of Wisconsin's State Constitution. Morgan and Elizabeth Martin lived in "Hazelwood," their beautiful home overlooking the Fox River south of Green Bay, now restored and open to the public. Their youngest daughter was Deborah Beaumont Martin who became Beaumont's Wisconsin historian and an important mainspring in Green Bay and Wisconsin history studies. Deborah Beaumont Martin died in 1931. Sophie Beaumont was also greatly interested in Wisconsin history and collaborated with Deborah Martin in writing several books on local history, still the standard references in Green Bay history. Both ladies were intensely interested in William Beaumont and did much to encourage the development of various memorials to him in this state. Sophie Beaumont died in 1936 after having spent much of her later years collecting Beaumont materials, which she shared with William Snow Miller for his 1933 article on Beaumont.[17] Eventually these documents were transmitted to the State Historical Society for permanent safekeeping and where they remain today as another tangible link to Wisconsin's Beaumont legacy.

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Doctor Larsen issues statement on "needless operations"

According to news reports, Ralph Andreano, PhD, administrator of the State Division of Health, told a Milwaukee audience that Wisconsin surgeons performed 77,000 needless operations in 1976, resulting in more than 400 deaths. In a telephone conversation with Society officials the next day, he claimed he was "misquoted."

In an immediate statement issued by the Society, President Roy B Larsen, MD, termed Doctor Andreano's remarks as "flimsy and baseless." He pointed out in a news release that Doctor Andreano appeared to be "pulling figures out of the air."

Doctor Larsen's statement continued, "the decision by a surgeon to recommend surgery is not taken lightly by the surgeon. Rather, it is the result of a rational, thoughtful analysis, taking into account the patient's unique situation and the physician's years of education and training."

"One thing should be understood: many operations are necessary, but not lifesaving. Who is the better judge of necessity: the woman with vaginal bleeding and her physician, or a statistician doing a survey? Who is to judge the necessity of a hemorrhoid operation that relieves the pain of the patient? How necessary is it to repair a hernia that gives a worker continuous pain, but could be made bearable by the use of a truss?

"Obviously, what is 'necessary' to one person may not seem so to another. To say that 400 people would be alive today if it were not for the care they received is totally without foundation. Furthermore, it should be remembered that thousands of people would be dead today if it were not for the operative care they received."

In a follow-up action, Doctor Larsen wrote a letter to Donald Percy, secretary of the State Department of Health and Social Services. In the letter the SMS President said, "These (Andreano's) assertions, if true, are appalling. If not true, the allegation is an equally appalling demonstration of the capability and willingness of a state agency to needlessly frighten the public and abuse physicians and other professions. As you know, we have already challenged the validity of these statements."

Doctor Larsen also requested "immediate study and remedial action" by the Department.

He requested the prompt release to the State Medical Society of the full details of the Department's studies on "unnecessary surgery;" and the immediate convening of a jointly sponsored, impartial review team to analyze the data upon which the assertions are based and to present a public report with whatever findings and recommendations are indicated. ■

Impaired Physician Program

The Commission on Mediation and Professional Ethics wishes to remind physicians of the Impaired Physician Program —helping the doctor suffering from alcoholism, other drug dependency or mental illness. Inquiries can be made to SMS headquarters in Madison: 608/257-6781, ext 133.

Wendle named to H-24 Steering Committee

William Wendle, coordinator of Continuing Medical Education for the State Medical Society, has been extended membership by the H-24 Steering Committee because of his efforts in representing physicians in the H-24 revision process.

The Steering Committee is advisory to the H-24 Council, which has statutory authority in revising the Hospital Administrative Code known as H-24. The code is nearing completion and should be scheduled for public hearing next spring.

At that time, notice will be given to all members and copies of the entire revised code proposal will be available. The following already are tentatively revised: governing body and management, occupational health, medical staff, nursing service, dietary, medical records, pharmaceutical services, laboratory, radiology, medical library, surgery, anesthesia, respiratory therapy, outpatient department, emergency service, social service, and research. ■

SMS Variable Annuity

. . . Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.296 as of August 31, 1977. ■

SMS supports liability statutes with briefs

The State Medical Society of Wisconsin has issued "friend of the court" briefs in support of the constitutionality of the malpractice statutes, Chapter 37, Laws of 1975.

In March 1977, Curtis M Kirkhuff, a Madison attorney with Oldenburg, Lent and Kirkhuff, SC, filed a suit against various aspects of the professional liability statutes and requested that the Supreme Court accept original jurisdiction in the case (see *WMJ*, May 1977, issue). The Supreme Court did take original jurisdiction, and all briefs on the part of the petitioners' respondents have been filed.

In addition to the briefs filed by the State Medical Society, friend-of-the-court briefs have been filed in support of the statutes by the Board of Governors of the Wisconsin Health Care Liability Insurance Plan and Patients Compensation Fund and the Wisconsin Hospital Association.

Briefs supporting Kirkhuff's challenge have been filed by the Wisconsin Academy of Trial Lawyers and the Medical Malpractice Committee of the State Bar. ■

Have you returned your Physicians' Opinion Survey?

By now, SMS physicians have received the Second Physicians' Opinion Survey in their mail. The SMS Council approved this survey to determine physicians' ideas and concerns on various new issues which weren't covered in the First Physicians' Opinion Survey in December 1975. Please return the survey promptly if you haven't already done so in order to insure that your opinions are voiced on these important issues. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of Aug 12, 1977

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

BROWN

Milson, Stuart E, 1745 Dousman, Green Bay 54303 (1934, Regular, Internal Medicine)

DANE

Bloch, Steven P, 2501 Post Rd, Madison 53713 (1947, Resident, Plastic Surgery)
Faris, John W, 1001 Gilbert Rd, Madison 53711 (1947, Regular, Psychiatry)
Klein, Ronald, 126 Forest St, Madison 53705 (1943, Resident, Ophthalmology)

LACROSSE

Agger, William A, 1836 South Ave, LaCrosse 54601 (1946, Regular, Internal Medicine/Infectious Diseases, Certified-IM)
Connelly, Mark V, 1836 South Ave, LaCrosse 54601 (1943, Otorhinolaryngology/Plastic Surgery, Certified-Oto)
Dahlberg, Philip J, 1836 South Ave, LaCrosse 54601 (1947, Regular, Internal Medicine/Nephrology, Certified-IM)
Jensen, Donald P, 1836 South Ave, LaCrosse 54601 (1944, Regular, Obstetrics and Gynecology)
Lockhart, Jack M, 1836 South Ave, LaCrosse 54601 (1945, Regular, Internal Medicine/Rheumatology, Certified-IM)
Pagliara, Anthony S, 1836 South Ave, LaCrosse 54601 (1937, Regular, Internal Medicine/Endocrinology, Certified-IM)

MILWAUKEE

Goetz, Roger A, 6565 N Alberta Ct, Milwaukee 53217 (1934, Regular, Anesthesiology, Certified)
Henry, Lyle G, 324 E Wisconsin Ave, Milwaukee 53202 (1944, Regular, General Surgery/Cardiovascular)
Hepperla, Roger L, 12750 Stephen Pl, Elm Grove 53122 (1932, Regular, Anesthesiology, Certified)
Pedraza, Pablo, 3112 W Highland Blvd, Milwaukee, 53208 (1941, Regular, 28, 1977 Cardiovascular Surgery/Thoracic, Certified)
Prudlow, William F, 8700 W Wisconsin Ave, Milwaukee (1944, Resident, Otorhinolaryngology)
Sternlieb, Richard O, 2388 N Lake Dr, Milwaukee 53211 (1927, Regular, Internal Medicine/Rheumatology, Certified-IM)
Wernick, Shelley, 759 N Milwaukee St, Milwaukee 53202 (1944, Regular, Neurological Surgery)

WOOD

Blau, Edward B, 1000 N Oak Ave, Marshfield 54449 (1938, Regular, Pediatrics/Nephrology, Certified-PD)
Canfield, Phillip R, 1000 N Oak Ave, Marshfield 54449 (1946, Regular Family Practice, Certified)

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Dietz, Richard J, Racine County, July 21, 1977
Weir, Earl F, Waukesha County, July
Henke, Samuel L, Eau Claire-Dunn-Pepin County, Aug 1, 1977
McCormick, George L, Waukesha County, Aug 1, 1977
Riegel, Jake A, Polk County, Aug 4, 1977 ■

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COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

August 6, 1977—Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Haskins at 1:05 pm on Saturday, August 6, 1977, at the State Medical Society.

Voting members present: Chairman Haskins; Vice-chairman Edwards; Councilors Schmidt, Foley, Nielsen, Steffen, LaBissoniere, Eisenberg, Waterhouse, Natoli, Lewis, Peters, Smejkal; Past President Picard, President Larsen, President-elect Levin, Speaker Motzel, and Vice-speaker Taebel.

Others present: Doctors Nordby, Derus, Collentine, Scott, Stuff, Correll, Viste, Lubitz; Mrs Charles Lyons, Auxiliary; Messrs Thayer, Maroney, Simms, Fetherston, Brower, Wendle, Johnson, Brown; Mrs Bartel and Miss Pyre.

2. Approval of Minutes of June 4, 1977

On motion of Doctors Picard-Eisenberg, carried, these minutes were approved with a correction that the matter of voting membership for an Auxiliary representative on the Physicians Alliance Commission was to be referred to the Executive Committee of the Council—item 8 C.

3. WHCRI-WisPRO Relationships

Doctor Correll reported on behalf of a special committee of physicians representing the Society, WHCRI and WisPRO, with recommendations on early implementation by the executive directors of the latter two entities of a Statement of Intent approved by all three organizations. This provided that WHCRI take steps to separately incorporate WisPRO with the boards of directors of the two organizations merged or overlapping to the extent feasible and allowed by federal law, the corporative bylaws of each being as identical as possible; with non-PSRO mandated programs executed under policies established by WHCRI; and with a single staff to serve both corporations.

The special committee asked that the two executive directors institute cross reporting responsibilities to coordinate and manage review and related activities with essentially a single staff; joint meetings for the present of the WHCRI and WisPRO executive committees, with the executive directors meeting regularly with both boards and the joint executive committees, and the preparation of a joint statement for any required HEW approvals.

The Council approved the recommendation of the special committee.

4. Report of Executive Committee

A. Physicians Alliance Commission Recommendations

(1) *Follow-up opinion survey of Society members*

The PAC proposed a follow-up survey of Society members with a shortened version of the opinion survey of all Wisconsin physicians, adding several new issues that have since arisen. The Executive Committee approved the proposal and forwarded it to the Finance Committee for action on the fiscal note estimated at $1,800.

Doctor Edwards reported that the Finance Committee had approved the fiscal note, and on motion of Doctors Larsen-Schmidt, carried, the Council approved the follow-up survey.

(2) *Medical Defense Committee recommendations*

This committee has recommended that the Society file amicus curiae briefs in two court appeals, one involving an expert witness question, and the other a claim that the insurance carrier did not live up to the professional liability contract to defend the insured until all remedies by appeal were exhausted, or a lack of good faith defense. The Executive Committee, by a vote of 3-2, recommended approval of the filing of briefs in both cases and referred the matter to the Finance Committee for action on the fiscal note estimated at $5,000.

Doctor Edwards reported that the Finance Committee had approved the fiscal note on the condition as to the second case that all other avenues of appeal are investigated, and specifically referral to the Insurance Commissioner on the failure of the insurance company to provide good faith defense.

On motion of Doctors Larsen-Picard, carried, the Council approved the actions of the Executive and Finance Committees.

B. Wisconsin Physicians Service Insurance Corporation (WPSIC)

The Council had received information relative to the disagreement over wording of the Transfer Agreement on the tradename "Wisconsin Physicians Service" and trademark "WPS." Doctor Larsen reported for the Executive Committee as follows:

"After lengthy discussion with the WPSIC Executive Committee and its attorneys and presentation of proposed substitute wording on the tradename issue drafted by Mr Horton for SMS and by Mr Kaufmann for

---

SMS ORGANIZATIONAL . . .

SMS members invited to South American Adventure in 1978

The State Medical Society is offering its members and their spouses a fine winter travel opportunity—a South American Adventure.

Through the services of INTRAV, a highly respected travel organization, the Society is sponsoring a nine-day trip to Peru and Ecuador, known as the Land of the Incas. The trip departs from Milwaukee February 26, 1978 and returns on March 6.

The vacation to the land of the Incas will provide participants with the opportunity to view the natural beauty of the Lima, Peru and Quito, Ecuador areas, the proud descendents of the Incas, plus the colorful village markets.

Price for the nine-day tour is $998 per person. Price includes airfare, hotels, and meals. In September SMS members were sent a colorful brochure giving details of the trip. If further information is desired, contact Society offices in Madison: 608/257-6781.

The Society is cosponsoring this tour with the State Bar Association and the Wisconsin Bankers Association. ■

Need a guest speaker for your county society meeting?

All county society presidents and secretaries are reminded that officers and staff of the State Medical Society, as well as delegates to the American Medical Association, are available to county societies as guest speakers at county society meetings. To arrange an appearance of a guest speaker at your next county society meeting, contact the physician directly, or work through the State Medical Society office in Madison. Please remember to give enough advance notice.

WPSIC, the Council's Executive Committee held further discussion, with action as follows:

"A motion by Doctors Picard-Haskins to recommend that the SMS go in the direction of separation from WPSIC lost by a vote of 3-2.

"On motion of Doctors Edwards-Levin, carried, the Executive Committee reports to the Council that it has negotiated the problem with the Executive Committee of WPSIC and has not been able to arrive at an agreeable alternative, and it therefore recommends that the following compromise wording be submitted to the Insurance Commissioner on Monday, August 8:

"SMS hereby assigns to WPSIC, as an asset transferred hereunder, the right of use of the trademark and tradename "WPS" and "Wisconsin Physicians Service" in connection with the operation of a health insurance plan. The right assigned hereunder shall revert to SMS as to either the trademark or tradename, whichever is applicable, or both, if WPSIC attempts to sell, assign, or dispose of its rights in them without the written consent of the WPSIC members, or if their use is discontinued by WPSIC.'"

The Council also received copy of a proposed letter to the Commissioner together with a report on a series of compromise proposals made by SMS to WPSIC concerning the tradename.

Doctors Larsen-Waterhouse moved approval of the Executive Committee action.

After discussion and questions were called for, the Council held an executive session and took action as follows:

Doctor Picard presented a resolution for Council consideration relating to continuing relationships between SMS and WPSIC.

Doctors LaBissoniere-Motzel moved to amend the motion on the floor to include Doctor Picard's resolution which appends the action of the Executive Committee on compromise wording relative to the trademark and tradename referred to in the main motion.

Doctor Waterhouse suggested the addition of an item 6 in the resolution that SMS in turn provide information to WPSIC. This was acceptable provided such information was limited to that properly related to WPSIC.

The amendment and main motion carried, with Doctor Peters voting in the negative on each. The resolution thus adopted reads as follows, "attaching" the wording quoted in the Executive Committee action reported above:

"WHEREAS, It is the desire of the Council, as the corporate membership of WPSIC, to preserve and enhance 31 years of effort by the State Medical Society to promote better health insurance through its insurance arm, Wisconsin Physicians Service, and

"WHEREAS, The new corporate relationship between SMS and WPSIC requires at least a period of cautious readjustment of the roles each plays under a new statute now therefore be it

"*Resolved*, That in the interests of continuing close relationships with the State Medical Society, and in the interests of the patients-subscribers served by Wisconsin physicians, the Council respectfully requests that the Board of Directors of WPSIC:

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"1. recommend jointly with the SMS to the Insurance Commissioner the SMS compromise wording relative to the tradename and trademark (see Item 4. B., paragraph 5, above);
"2. recognize the three Councilors on the WPSIC Board of Directors as the official liaison members of SMS with WPSIC since by their election by the Council they are clearly regarded by it as capable and competent representatives of the interests of the SMS;
"3. make no less than quarterly formal reports to the corporate membership both in writing and by personal appearance of the President or Chairman of the Board, or both, or in their unavailability, their designees;
"4. provide to the Chairman of the Council, at the same time these are distributed to the WPSIC board members, copies of all agendas and supporting materials for meetings of the WPSIC Board of Directors and its Executive Committee;
"5. name to the Executive Committee of the Board of WPSIC, for at least the next three years, one of the Councilors of SMS on the Board as recommended by the corporate membership, thus assuring a full and open communication between the Council and WPSIC in the initial years of the transfer.
"6. In consideration of item 4 above, the Chairman of the Board of WPSIC is to receive from the SMS for information those portions of agenda and supporting materials for meetings of the Council and its Executive Committee as are properly related to WPSIC.

"and be it further

"*Resolved,* That if these evidences of good faith relationships with the Council cannot or will not be provided by WPSIC, the Council recommend to the House of Delegates in April 1978 that the corporate relationship between the SMS and WPSIC be dissolved by the most expeditious means possible, and that this recommendation be accompanied by an advisory referendum of the membership on the issue prior to the meeting of the House."

C. Peer Review for Medical Examining Board

In a meeting of Society officers and staff with the Medical Examining Board, it was agreed that improved two-way communication between the Board and the medical profession was urgently needed, and that better methods for handling complaints, allegations, and potential disciplinary problems should be initiated. The Society suggested that the Board utilize peer review services in support of its efforts to ascertain competence of performance. In response to the anticipated request from the Board for names of physicians upon whom it can call for consultative peer advice, the Executive Committee recommend that names of the entire Commission on Peer Review be submitted with identification of specialties.

On motion of Doctors Larsen-Levin, carried, this recommendation was approved by the Council.

D. Miscellaneous

The committee reported actions authorizing out-of-state meeting attendance by a committee chairman; approval of Work Week of Health plans and preliminary planning for 1978 annual meeting socioeconomic luncheon and dinner affairs.

E. Ad Hoc Study Committee

On motion of Doctors Larsen-Picard, carried, the Council approved the appointment of an ad hoc committee to study and make recommendations on the better integration of Society activities in continuing medical education, peer review, mediation and ethics, PSROs and HSAs.

Chairman Haskins appointed Doctors Lewis (chairman), Levin and Natoli representing the Council, and the chairmen of the affected commissions of the Society.

5. Report of Finance Committee

Doctor Edwards reported that as the Managing Committee and Trustees of the Employees Pension Plan, the investment portfolio was reviewed with investment counsel who believe it is in a good position to take advantage of anticipated market changes, and that the established investment guidelines for management of the fund are acceptable and in compliance with ERISA and other laws. He reported for information that the committee, after careful consideration, has appointed a new actuarial firm for the Plan, A S Hansen, Inc, a national organization with a Milwaukee office. It was further reported that IRS has issued a favorable determination letter on the revised Plan and Trust Agreement.

The Finance Committee reviewed the status of membership dues receipts, noting that an additional $80,000 of dues income is needed to make the budgeted amount. It also reviewed the budget-expense report as of June 30, including a comprehensive analysis of legal expenses, which is nearly $20,000 over budget. Staff continues efforts to hold down these expenses and has instituted a control procedure whereby all requests for outside legal services must be cleared through Assistant Secretary Maroney in advance and in writing.

Doctor Edwards reported for information that the Medical Society of Milwaukee County has moved its office and along with it the two Society employees assigned to the Physicians Alliance Division. Rent and all other costs related to their functions in that office are paid by the SMS dues structure.

On motion of Doctors Edwards-Picard, carried, the report was accepted.

6. Report of Committee on Economic Medicine

Doctor Schmidt summarized the current situation with the state liability insurance plan as reported by Mr Thatcher, insurance consultant to the committee and member of the Board of WHCLIP. A report was also received from the latter on contacts with ten companies concerning possible quotations on general liability umbrella coverage; all declined, but one may be reconsidering this type of activity.

Mr Thatcher also had prepared at the request of the committee an insurance check list which a physician or his insurance consultant could use to ascertain any unprotected areas and determine the need for either additional coverage or adjustments. The committee recommended that the check list be sent in a separate mailing to members with an explanatory cover letter.

On motion of Doctors Edwards-Lewis, carried, the recommendation and fiscal note were approved by the Council.

The committee, because of a situation which has come to its attention, will through its chairman request WPS to review current membership status of those physicians participating in the SMS health insurance programs. Any proposal to cancel members whose dues may not be paid should be explored with WPS as a policy matter.

The committee discussed the problem of physicians having to terminate or convert membership insurance programs when they move out of Wisconsin and SMS membership is a requirement for participation.

Doctors Schmidt-Picard moved that the Council consider a new category for continued membership at a reduced fee for those leaving the state, on a selective basis; motion carried.

It is anticipated that the committee will make a specific recommendation to the Council.

7. Report of Nominating Committee

On motion of Doctors Picard-Natoli, carried, the Council approved the committee's nomination or alternate for a vacancy on the Committee on Rural Health.

The Council was informed that the committee has initiated the complicated process of seeking nominations for "public" members on the WPSIC Board of Directors.

8. Commission on Governmental Affairs; Committee on Federal Legislation

Doctor Lubitz reported on the status of state legislation of special interest, requesting letters to legislators or appearances at hearings.

He indicated that the Committee on Federal Legislation, in its study of HR 1603 which would require patient package inserts with drugs, is considering a proposal that each county medical society establish a telephone information service for consumers, or possibly through Poison Control Centers.

The Council had reservations about associating the drug information with Poison Control Centers, and on motion of Doctors Lewis-Edwards, carried, requested that this be explored further.

In reference to a Council agenda item concerning the AMA's request of state societies for recommendations by September 10 with regard to National Health Insurance, Doctor Lubitz inquired whether the Committee on Federal Legislation should respond after consideration of the subject at an August 31 meeting.

Mr Thayer reported that the AMA had been contacted and would prefer to have the response come through the Council as official policy. Consequently, the matter will be scheduled for Council review at its October meeting.

9. Physicians Alliance Commission

Doctor Viste summarized a written report from the Commission including the status of Title 19 provider contract and

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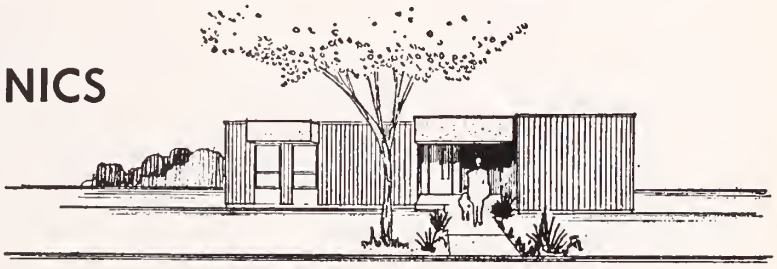

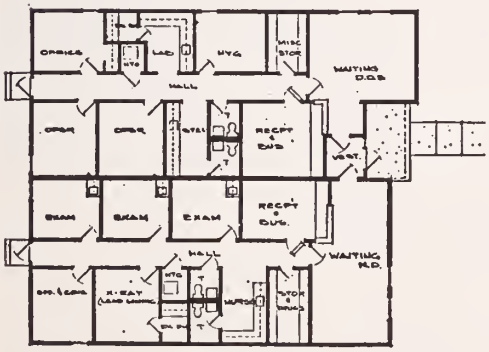

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administration by EDS; preliminary meetings with representatives of other health providers looking to coordination of legislative and political action. He expressed appreciation for the Council's support of the Medical Defense Committee in approving the filing of amicus curiae briefs in two test cases.

10. Commission on Heallth Facilities and Services

This report related to commission ongoing studies of emergency medical technicians; H-24 administrative code rules on discharge planning in hospitals subject to state review; planning for an educational program for county societies on health planning (HSAs) to be coordinated with the Physicians Alliance. The commission also approved a policy statement of the Wisconsin Chapter of the American Academy of Pediatrics on rubella as follows:

> "That the Wisconsin Chapter of the American Academy of Pediatrics recommend to hospital administrations that famale personnel of child-bearing age working in pediatrics, nurseries, and renal dialysis be informed of the potential risk to a fetus from exposure to patients with recognized virus, e.g., rubella.
>
> "That the rubella titer of female personnel be determined before working in these areas.
>
> "Those with low rubella antibody titers be offered rubella immunization before commencing their employment, unless, of course, they are currently pregnant."

11. Commission on Continuing Medical Education; nonmember registration fee

This commission recommended that the previously established $100 annual meeting registration fee for Wisconsin nonmember physicians be reduced to $25, be included in the printed annual meeting program and enforced.

On motion of Doctors Picard-Schmidt, carried, the recommendation was approved by the Council.

12. Commission on Public Information

This report informed the Council of new projects recently undertaken by the commission involving the development in all county medical societies of public relations committees and communications with the news media; also the preparation of advertisement mats for use by county societies in newspaper campaigns to express the physician viewpoint on the issue of rising health care costs.

13. Commission on Peer Review; proposed medical necessity program for T-19

The Council had received information concerning the DHSS proposal to adopt the essentials of a "medical necessity program" developed by National Blue Shield in which certain outmoded or questionable surgical and diagnostic procedures would be paid for by Blue Shield plans only upon satisfactory justification by the physician. DHSS, on the contrary, would eliminate payment under Title 19 for 21 procedures and require prior authorization for 11 others.

The Commission on Peer Review recommended that Wisconsin Medicaid should follow the National Blue Shield policy of requiring acceptable justification for the performance of any one of the 32 identified procedures; further that the Society ask DHSS to profile the practice pattern of physicians who bill for any of the services and provide the commission with the results for analysis and possible advice to the Department. The Commission would request that DHSS send to it all copies of written justifications for therapeutic procedures and a copy of the profile of physicians involved with diagnostic procedures; would review all such information, work with the physicians involved in the correction of any practice patterns that indicate the need for education; and provide advice to DHSS in the handling of individual cases and possible recommendations for overall policy dealing with these procedures.

On motion of Doctor Edwards, seconded and carried, the report and recommendations were accepted by the Council.

14. Special Planning Meeting of the Council, September 16-17

The timetable and general plans for this meeting were accepted as presented.

15. "Unlimited" License and Membership Eligibility

In 1970 the Society's Bylaws were amended by the addition of the underlined words in Chapter I, Section 4: "Every reputable and legally qualified physician, *who holds an unlimited license to practice medicine and surgery*. . . . shall be eligible to apply for membership.

The purpose of the amendment at the time was to open the way to state society membership for doctors of osteopathy elected by county societies who held the same license as doctors of medicine and surgery.

The Society is aware that on occasion the Medical Examining Board may place certain restrictions on some physicians as a method of controlling individual situations. As an example, the Board may restrict a physician from prescribing certain drugs. At the same time, the Society may not know of all such situations. The question presented was whether the word "unlimited" would disqualify such a physician for membership and the continuation of member benefits.

On motion of Doctors Smejkal-Natoli, carried, the Council recommended House of Delegates action on a Bylaw amendment to delete the word "unlimited" from the quoted section.

16. Referrals from House of Delegates to Council

Deferred to the next regular Council meeting.

17. Specialty Section Representative on GAC

On motion of Doctor Waterhouse, seconded and carried, the appointment of Carl Eisenberg, MD, as the Section on Pediatrics representative on the Governmental Affairs Commission was confirmed.

18. State Board of Nursing

With the retirement of John Hirschboeck, MD, appointed to a four-year, unexpired term in 1974, there is a vacancy on the Board of Nursing. The statutes specify that the board shall include "one person from the state medical society."

On motion of Doctors Smejkal-Peters, carried, the Council approved the nomination to the Governor of Drs Elmer P Rohde and Robert D Heinen, subject to their agreement.

19. Secretary's Report

The Secretary submitted a "sequel to sore throat" reporting the negative results of the complaint to the National News Council concerning the *Milwaukee Journal* series of articles alleging Medicaid rip-off; also reporting the retirement of Marguerite Cordts.

On motion of Doctors Schmidt-Edwards, carried, the Council commended Marguerite for her many years of dedicated service and requested that an appropriate remembrance be presented to her.

20. Proposed National Immunization Program

The Secretary reported a communication from the Indiana State Medical Association concerning a Carter Administration proposed immunization program apparently modeled after the "swine flu" program. The Wisconsin Task Force on Immunization and Health Screening recommended support of the Indiana approach in opposition to a national immunization program and in favor of immunization through the private sector in cooperation with the State Division of Health.

On motion of Doctors Schmidt-Waterhouse, carried, this recommendation was approved.

21. Adjournment

The meeting adjourned at 4:20 pm.

EARL R THAYER
Secretary

Approved October 15, 1977
PAUL S HASKINS, MD
Chairman

NEWS HIGHLIGHTS

Miss Elizabeth Terry
. . . retired Sauk County supervisor of public health nurses, was recognized by the Sauk County Medical Society for her 32 years of faithful service to the community, at its September 13 meeting in Baraboo. Miss Terry is shown above with Melvin F Huth, MD,* Baraboo, president of the Society, who presented her with a plaque that expressed the Society's appreciation. (Staff photo by Ken Opin)

Wisconsin Society of Internal
. . . Medicine recently held elections of new officers for the year 1977-78 at its annual meeting in September. They are MDs Michael Mehr, MD*, Marshfield, president; John P Mullooly, MD,* Milwaukee, president-elect; and Michael J Mally, MD,* Hartford, secretary-treasurer. The annual meeting for next year will be September 15-16, location to be announced later.

Kimberly-Clark Health
. . . Management Program was introduced to the public October 7 when the company held a news conference at its Health Services Center, located at the K-C West building, Winchester Road (Highway 150), 1-1/2 miles west of Highway 41, in Neenah.

William Wicks, staff vice president, explained that the Program is probably one of the most comprehensive that is conducted on a company's own premises for such a large group of employees. The K-C Corporation has 2,100 salaried employees in the Fox River Valley area. Wicks said:

"Life-style" has become the key phrase in modern health care. Many medical authorities agree that medicine and technology alone cannot adequately prevent or treat the principal diseases threatening today's society—cancer, heart trouble, and stroke. Instead, individuals have to recognize that how they live may determine how long they live—and in what physical condition.

Briefly, the Health Management Program works this way: The health risks of each employee are evaluated in the multiphasic testing unit which has been constructed as part of the Health Services Center. Once this evaluation has been made, the employee is given a "health prescription" which, in effect, asks him to make a commitment to a change in life-style. The prescription may call for supervised exercises in the new physical fitness facility which also is part of the Health Services Center; or it may call for health education and/or counseling.

Embarking on this program is explained by the K-C Corporation this way: First, K-C recognizes that it has a major investment in employees. By helping them maintain or improve their health through a change in life-style, the company believes that productivity will be enhanced by better job performance and less absenteeism due to illness. Second, as with other major employers, K-C's costs for employee medical insurance coverage have been spiraling. This program may help hold the line on costs and perhaps eventually reduce them.

Robert Dedmon, MD,* Neenah, is director of the Health Management Program. Six physicians serve on an advisory board: Charles Fenlon, MD;* Bernard Haza, MD;* Gilbert Mueller, MD;* and Lowell Peterson, MD;* Appleton; and Erdal Gursoy, MD* and Edward Scanlon, MD,* Neenah.

The trend toward changing life-styles is gaining impetus.

Over 400 companies in the US, including several in Wisconsin, have instituted some type of employee health promotion program.

The State Health Planning Council has developed a model program to provide general guidelines and suggestions for developing such a program. By June 30, 1978, the HPC plans to have three pilot prevention and health promotion programs established in various sizes and types of work place settings. ■

PHYSICIAN BRIEFS

Roger W Kwong, MD
Anthony S Pagliara, MD*
William D Platt, MD

. . . recently became associated with the Gundersen Clinic Ltd-LaCrosse Lutheran Hospital. Doctor Kwong graduated from the University of Minnesota Medical School and completed his internship and residency at Stanford University Medical Center in California. He also completed a residency and fellowship in medical oncology at University of Minnesota Hospitals. Doctor Pagliara, specialist in endocrinology, graduated from Albany Medical College, New York, and interned at Albany Medical Center Hospital. He completed residency training in a fellowship in endocrinology at Albany Medical College. Prior to joining the Clinic medical staff, Doctor Pagliara had been associate professor of medicine and pediatrics, and co-director of pediatric endocrinology and metabolism at St Louis Children's Hospital, St Louis, Mo. Doctor Platt graduated from the Medical College of Wisconsin, Milwaukee, and served his internship at University Hospitals in Madison. He completed his residency training at the University of Washington, Seattle.

Mark V Connelly, MD*
Donald P Jensen, MD*

. . . have joined the medical staff of the Gundersen Clinic Ltd-LaCrosse Luthern Hospital. Doctor Connelly, an otolaryngologist who specializes in plastic and reconstructive surgery, graduated from the University of Iowa. He completed his internship and residency requirements in general surgery at Gundersen Clinic-LaCrosse Lutheran Hospital and his otolaryngology residency at the University of Iowa. Doctor Connelly served in the United States Navy for two years prior to joining the Clinic. Doctor Jensen, an obstetrics and gynecology specialist, received his medical degree from the University of Illinois College of Medicine in Chicago. He completed his internship at Gundersen Clinic-LaCrosse Lutheran Hospital, and his residency at the University of Utah College of Medicine in Salt Lake City. Doctor Jensen served in the United States Army for two years stationed at Ellsworth Air Force Base in South Dakota.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

William A Agger, MD*
Philip J Dahlberg, MD*
Jack M Lockhart, MD*

. . . have become members of the medical staff of the Gundersen Clinic Ltd-LaCrosse Luthern Hospital in LaCrosse. Doctor Agger, infectious disease specialist, graduated from the University of Illinois Medical School, Chicago, and completed his residency at Gundersen Clinic-LaCrosse Lutheran Hospital. He also completed a fellowship at University of Wisconsin Hospitals in Madison. Doctor Dahlberg, nephrology specialist, graduated from the University of Iowa Medical School, Iowa City, and completed his internship and residency at Gundersen Clinic-LaCrosse Lutheran Hospital. A fellowship in nephrology was completed at Mayo Clinic, Rochester, Minn. Doctor Lockhart, specialist in rheumatology, graduated from Harvard Medical School, Boston. He interned at University Hospitals, Cleveland, Ohio, and was in the United States Army at Ft Sheridan, Ill. He completed his residency at the University of Minnesota Hospitals and had been an instructor of medicine at the University of Minnesota Hospitals.

Steven J Fass, MD

. . . Beloit, recently joined the medical staff of the Beloit Clinic. A 1971 graduate of Columbia University College of Physicians and Surgeons, Doctor Fass was a staff physician at the Baltimore Free Medical Clinic and a visiting physician in the Gastrointestinal Clinic of Baltimore City Hospital. His residency was completed at University Hospital, Boston University Medical Center. He also served in the United States Public Health Service stationed at the Gerontology Research Center of Baltimore, Md, from 1973-1974.

John C Weber, MD*

. . . Milwaukee, has joined the staff of Radiology Associates of Beaver Dam, Ltd. Doctor Weber was a fellow in radiology at the Mayo Clinic from 1959-1962. He practiced radiology in Springfield, Ill, from 1962-1964 and joined the radiology department at Columbia Hospital in Milwaukee in 1965.

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF SEPTEMBER 1977

1	Task Force on Health Screening and Immunization
6	Dane County Medical Society Board of Trustees
7	Title 19 Provider Groups
9	Dual Hospital Survey
9	SMS Physicians Alliance Commission
9	Wisconsin Chapter, American Academy of Pediatrics
15	Board of Directors. Wisconsin Council of Professions
16	*SMS Special Council Meeting (Wausau)*
17	*SMS Special Council Meeting (Wausau)*
20	H-24 Steering Committee
21	WisPRO Executive Committee Board of Control
21	WisPRO Advisory Group
22	SMS Commission on Health Facilities and Services
24	SMS Commission on Mediation and Professional Ethics
25	SMS House of Delegates Nominating Committee
26	State Auxiliary Nominating Committee
27	Dane County Health Resources Committee
30	Subcommittee on Accreditation, SMS Committee on Continuing Medical Education

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parenthesis.

Michael J Reinardy, MD

. . . Neopit physician for five years, recently joined the medical staff of The General Clinic in Antigo. He graduated from Marquette University School of Medicine in 1966 and served in the United States Army from 1967-1970. His residency training was served at Hennepin County General Hospital in Minneapolis, Minn.

Ronald Gurney, MD
Nalini Madan, MD
Kitcha Ruangchakrapetch, MD

. . . recently joined the medical staff of Beloit Memorial Hospital as emergency room physicians. Doctor Gurney graduated from Southern University of New York Downstate Medical Center and served his internship and residency in internal medicine at Albert Einstein Medical Center, Philadelphia. Doctor Madan, a native of Rajasthan, India, attended medical school in India and served a residency in pediatrics at Children's Hospital of Michigan in Detroit. Doctor Ruangchakrapetch attended medical school and interned in Thailand. His surgical residency was taken at Flushing Hospital in Flushing, NY.

Vincenta Salanova, MD

. . . Monroe, recently became associated with the medical staff of the Monroe Clinic in the Department of Neurology. Doctor Salanova received her medical degree from the University of Madrid. She completed a rotating internship at Holy Name Hospital, Teaneck, NJ, and was at Kingsbrook Jewish Medical Center in Brooklyn, NY. Her neurology residency was taken at St Louis University Medical School.

Robert E Holt, MD

. . . Madison, recently opened his office in the practice of psychiatry. A 1971 graduate from the University of Pennsylvania School of Medicine, Doctor Holt served his internship at the University of Wisconsin, Madison. His residency in psychiatry was completed at the University of Chicago. Doctor Holt served in the United States Army for two years, stationed in Korea and Fort Carson, Colo.

Rolf Naley, MD

. . . recently became affiliated with the Ladysmith Medical Center, a satellite clinic of the Marshfield Clinic. A 1973 graduate from the University of Minnesota Medical School, Doctor Naley completed his family practice residency in Salt Lake City, Utah.

Carleton B Davis, MD
Jan G deWaal, MD

. . . recently became associated with The Monroe Clinic. Doctor Davis, a specialist in internal medicine, graduated from the University of Virginia Medical School in 1970 and served his residency at the University of Maryland and Mercy Hospital, Baltimore. He served in the United States Army Medical Corps for two years, serving in Korea and at Walter Reed Army Hospital. Doctor deWaal, an orthopedist, graduated from the University of Amsterdam, The Netherlands, and served his residency at Duke Medical Center in Durham, NC. He joined the United States Navy in 1957 and served at Bethesda, Md, Naval Hospital, Vietnam, Boston, and most recently was chief of orthopedic surgery at the Naval Center in Charleston, SC.

Robert E Wampler, MD

. . . recently became associated with the Beaumont Clinic, Ltd, Green Bay. Doctor Wampler is a 1969 graduate of the University of Iowa Medical School, Iowa City, and served his internship at St Paul Ramsey Hospital, St Paul, Minn. His residency in internal medicine was taken at University of Iowa, Iowa City.

Michael S Faudree, MD

. . . recently became associated with MDs James A Clemence,* Robert B Jachowicz,* and Robert S Chudnow (Whitnall Family Practice), Hales Corners. Doctor Faudree graduated from the University of Washington School of Medicine and completed his family practice residency at St Luke's Hospital, Milwaukee.

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Judy Zwemer Bennington, MD

. . . Mason, recently became associated with the Ashland Eye Clinic. Doctor Bennington graduated from the University of Michigan Medical School in 1967, and served her residency in ophthalmology at the University of Minnesota Hospitals, Minneapolis. Prior to joining the Clinic, she was a clinical instructor in the Department of Ophthalmology, University of Minnesota, and practiced at Group Health, Inc, in St Paul.

Dan T Cleary, MD

. . . Oconomowoc, has become associated with Michael G O'Mara, MD,* in the practice of Internal Medicine. A 1971 graduate of the University of Wisconsin Medical School, Madison, Doctor Cleary served his internship and residency at Santa Clara Valley Medical Center in California. Doctor Cleary is on the associate staff at Oconomowoc Memorial Hospital.

Lawrence G Crowley, MD*

. . . Dean of the University of Wisconsin Medical School, Madison and Acting Vice Chancellor for Health Sciences, recently resigned to assume the position as Deputy Dean of Stanford University School of Medicine in California. Doctor Crowley has been Dean of the University of Wisconsin Medical School and professor of surgery since 1973. He was appointed Acting Vice Chancellor for Health Sciences in May following the resignation of Robert E Cooke, MD*, who is now the president of the Medical College of Pennsylvania.

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Robert Piat, MD

. . . Berlin, has become associated with L J Seward, MD,* in Berlin. Doctor Piat graduated from the University of Maryland School of Medicine and served his residency, in surgery, at White Memorial Medical Center, Calif. Prior to his surgical residency, Doctor Piat practiced in Zephyr Hills, Florida, and served with the public health service in Arkansas.

Gerald E Osband, MD

. . . a member of the Department of Family Practice, Wausau Medical Center, received the first Warner-Chilcott Teacher Development Award. Doctor Osband has been with the Wausau Medical Center since August. He graduated from the University of California-San Francisco Medical School and served his residency at the University of Minnesota Hospitals.

Ray M Thorpe, MD
Earl W Zabel, MD

. . . recently became associated with the medical staff of the Wausau Medical Center. Doctor Thorpe graduated from Cornell University Medical School and served his internship and residency in radiology at the University of Utah Medical Center, Salt Lake City. Doctor Zabel graduated from the University of Wisconsin Medical School, Madison. His residency in obstetrics and gynecology was at Sparrow Hospital, Lansing, Mich, which is affiliated with the University of Michigan.

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Michael J Chojnacki, MD

. . . Oconomowoc, recently was appointed a member of the medical staff of Milwaukee Psychiatric Hospital. Doctor Chojnacki graduated from Pritzker School of Medicine, University of Chicago, served his internship at University Hospitals, Madison, and his residency at the Columbia-Presbyterian Medical Center, New York, NY. He is an assistant professor in the Department of Psychiatry of the Medical College of Wisconsin, Milwaukee.

Richard Leer, MD
Rex McConnell, MD
Alan McKenzie, MD

. . . recently became associated with the medical staff of the Marshfield Clinic. Doctor Leer graduated from the University of Texas Southwest Medical School, Dallas, and served his internship at Hennepin County General Hospital, Minneapolis. His residency in family medicine was taken at Camp Pendleton Naval Hospital, Calif. Doctor McConnell has joined the Department of Immediate Care. He graduated from Wayne State University, College of Medicine in Detroit, and served his internship at St Joseph Mercy Hospital, Detroit. Doctor McConnell previously practiced for ten years in Marquette, Mich, served with the Alexian Brothers Hospital, Chicago, and served 13 months in general practice in Brownstown, Jamaica, Health Centers. Doctor McKenzie, an internal medicine specialist, graduated from the University of Michigan Medical School. He completed both a residency and fellowship there. His internship was taken at Albany, NY Medical Center.

David Corser, MD*

. . recently has been appointed clinical assistant professor of pediatrics by the University of Wisconsin Medical School. The pediatrician will continue his full-time practice at Skemp-Grandview Clinic in LaCrosse but will assist in the education of medical students assigned to LaCrosse for clinical experience. The teaching appointment is for a three-year term. Doctor Corser is board certified from the American Board of Pediatrics, a member of the American Academy of Pediatrics, and past chairman of the Western Wisconsin Regional Newborn Center Steering Committee.

Kevin Parent, MD*
Paul Mitchell, PhD

. . . gastroenterologist and microbiologist, respectively, both of the Marshfield Clinic, are the principal investigators in a two-year study of rare and unusual bacteria as a possible cause of Crohn's disease (ileitis), a condition which has puzzled medical science since its discovery in 1932. The study has been funded with close to $50,000 from the National Foundation for Ileitis and Colitis. The suspect bacteria, taken from the tissue of Crohn's disease patients, has not been found in any other disease process. As part of their study, the doctors will continue to take tissue disease at the Marshfield Clinic each specimens from the 30 to 40 patients who undergo surgery for Crohn's year, and will attempt to transmit the disease to experimental animals through innoculation.

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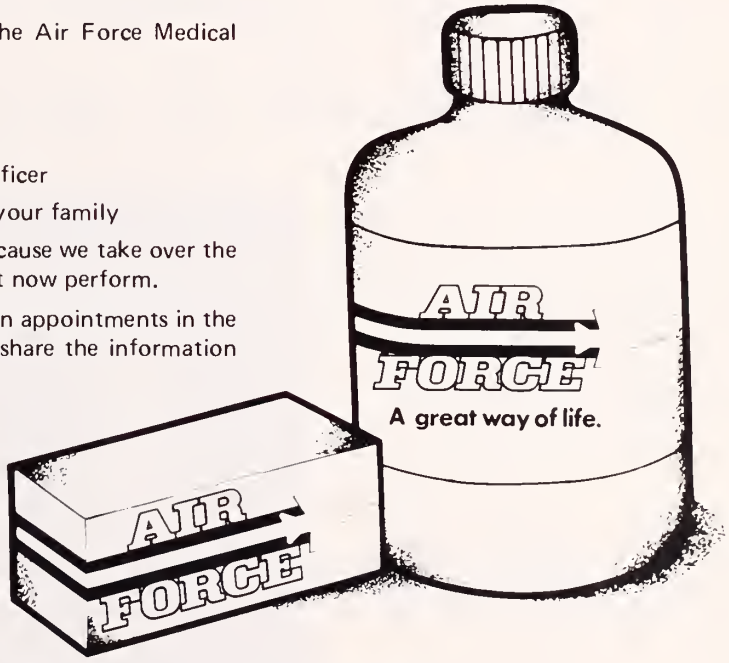

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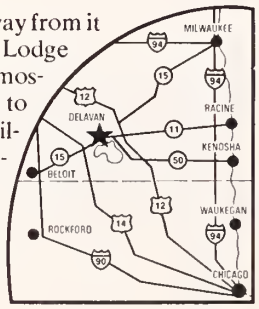

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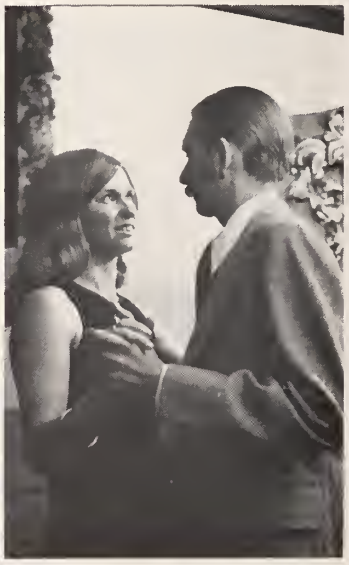

WANTED: PHYSICIAN IN COMmunity of 625 population with trading area of 3600 population. Building is equipped with chairs, desks and files. Contact Jno W Meyer, Boyd, Wis 54726. 8tfn/77

PRIMARY CARE PHYSICIAN-INternist or general family practitioner with or eligible for Wisconsin licensure for a teaching hospital-medical school affiliated primary care center located in Milwaukee's inner city. The appointee will work as a member of an existing group of full-time faculty primary care physicians. Salary commensurate with qualifications and experience. For a suitably qualified appointee opportunity for faculty appointment. Position available for immediate appointment. Send CV or contact Gerard T Parent, MD, Downtown Medical and Health Services, 2430 West Wisconsin Ave, Milwaukee, Wis 53233. An Equal Opportunity Employer. 8tfn/77

GENERAL SURGEON, BOARD certified, to join well-established incorporated family practice clinic located on southwest side of Milwaukee. Three accredited hospitals, new office building, friendly community. Salary first year, with increasing percentage of net; working to partnership. Call 414/643-4470. Mrs Reiff. 8-10/77*

SEVEN PHYSICIAN (4 FAMILY Practice) incorporated group in Green Bay, Wis, seeking family physician. Competitive salary and clinic package plus living in a growing area with cultural and recreational advantages. Please contact Mr Jeff Rosemann, Business Manager, 1751 Deckner Ave, Green Bay, Wis 54302. 11tfn/76

MEDICAL ASSOCIATES OF BEAver Dam has an opening for a family physician. Nine-member clinic, 7 of whom are family physicians. Equal distance from Milwaukee and Madison. Further details, call or write: S G Cupery, MD, 1200 N Center St, Beaver Dam, Wis 53916; tel 414/887-7101. 6tfn/76

PHYSICIAN-GP. AN OPENING exists for a Medical Director at the Wisconsin Correctional Institution, Fox Lake, Wis. Duties consist of supervising medical program for a modern institution of about 500 men. Five-day, 40-hour work week with infrequent evening calls. All surgery is performed at University Hospitals, Madison. Ideal for a physician who does not prefer the pressure of private practice. Possession of a Wisconsin medical license required. A physician desiring less than 40 hours per week may be considered. Fox Lake is an ideal location for outdoor summer sports and winter recreation. Located in Dodge County near Waupun and Beaver Dam. Salary dependent upon training with excellent civil service and retirement benefits. Contact Warden John R Gagnon, Box 147, Fox Lake, Wis 53933, or call Fox Lake 414/928-3151. An Equal Opportunity Employer. 5-10/77

FAMILY PRACTITIONER AND pediatrician wanted to join 10-man multispecialty group. Many corporate benefits. Rapidly growing community of 20,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, P O Box 178, West Bend, Wis 53095. 7tfn/76

PHYSICIAN WANTED TO PERform light physicals five days per week in the Milwaukee area. Ideal job for retiring physician. Contact Mike Stough, collect, at 513/621-8728. 9tfn/77

WELL-ESTABLISHED FAMILY Practitioner seeking associates in small, friendly community. Access to four excellent medical facilities. Fox River Valley area. Partnership potential. Reply to Box 242, Little Chute, Wis 54140. p9-11/77

WANTED: GENERAL SURGEON, board certified or eligible to join eight man family practice group in University town with trade area population of 22,000, 30 miles southeast of St Paul, MN. JCAH approved hospital. Contact David Woeste, MD, River Falls Medical Clinic, Ltd, River Falls, Wis 54022, or call collect 715/425-6701. 9tfn/77

MEDICAL DIRECTOR-WISCONSIN State Prison, Waupun, Wis, must be eligible for licensure to practice medicine in Wisconsin. Duties: Supervise and provide medical services to residents at maximum security adult male correctional institution, responsible for administration of hospital, coordinate activities within hospital with other outside medical facilities. Pay: Start between $14.730 per hour ($2563 per mo) and $18.056 per hour ($3141 per mo) based upon qualifications of applicant. Receive increase after six months. Equivalent salary: Approx $31,860 to $38,796 annually. Waupun is attractive community of 8000, varied recreational facilities, excellent school system, near Horicon Marsh Wildlife Refuge. Write to Glenn R Weeks, Personnel Manager, Box C, Waupun, Wis 53963. An Equal Opportunity Employer Functioning Under An Affirmative Action Program. 9-10/77

EMERGENCY PHYSICIAN: PARTtime ER physician wanted for one or two weekends a month in a quiet emergency department. Work 12 to 60 hour shift. $20 per hour plus use of furnished home adjacent to hospital. Conscientious back-up by medical staff. Wisconsin license and malpractice insurance required. Contact Philip T Eckstrom, MD, Rt #1, Box 254, Peshtigo, Wis 54167. Tel: 715/582-3315. p9-10/77

MEDICAL FACILITIES

OFFICE FACILITIES WITH COMplete laboratory and x-ray for general practitioner, internist or OB-GYN located in Medical Arts building, Southwest suburb of city of Green Bay, Wis. Easy access to three hospitals. G E LeMieux, MD, PO Box W-200, De Pere, Wis 54115. 10-12/77

FOR RENT: MEDICAL OFFICES located in Milwaukee suburb. Airconditioned, carpeted, parking lot. Share lab, x-ray, and switchboard facilities. Phone 414/771-0500 for daytime and 414/781-1497 nights. 9-10/77

RETIRED GENERAL SURGEON'S professional equipment for sale. Can be purchased in entirety or separately. Call 608/846-5661 between 8:30-10 PM. 8/77*

FOR SALE: ENTIRE OFFICE AND medical equipment of deceased doctor who was engaged in general practice and surgery in the Village of Waterford, Racine County, Wis. Office used by doctor available for lease. Call 414/539-2868. g9tfn/77

FOR SALE: MEDICAL BUILDING; waiting room, reception desk, lab room, eight examining rooms. Pharmacy in building (also for sale). Located in a rapidly growing area of Sturtevant, Wis, Four miles west of Racine. Please write or call collect to Robert C Cotter, RPh, 8700 Racine Ave, Hwy 11, Sturtevant, Wis 53177. Tel: 414/886-4178. 9-10/77

WANTED TO BUY: EXAMINAtion room table, horizontal file, cabinets, office furniture, etc. Contact: E G Arellano, MD, tel: 414/324-5043 or 414/324-5581. 5tfn/77

OFFICE SPACE FOR RENT: Courtland Medical Center Building. Excellent location - 68th at West Capitol Drive, Milwaukee, Wis. Full lab and x-ray facilities available. Call 414/463-3704. 3/77*

FOR SALE: MEDICAL BUILDING. Presently leased to two dentists and two MDs. 33-car parking lot, air-conditioned, Northeast Madison. Beautifully maintained, priced to sell. Joha Realty Co. Tel: 608/241-2083 8-9/77*

FOR LEASE: OFFICE SPACE. Professional building, 2888.5 sq ft. Reception room, air-conditioned, 33-car parking lot, can accommodate 2 to 3 MDs, Northeast side of Madison. Joha Realty Co. Tel: 608/241-2083. 8-9/77*

MEDICAL OFFICE FURNITURE: Examining table, upright cabinet, equipment table, desk with chair and 6 wooden arm chairs—used in waiting room. Will contribute to anyone who will pay the cost of moving them. Contact Mrs John M Albino, 438 Shoreland Dr, Racine, Wis 53401. g8tfn/77

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77 ■

NINETEENTH MEETING OF THE WISCONSIN NEUROLOGICAL SOCIETY

Friday-Saturday, October 28-29/ Heidel House, Green Lake

Approved for Category I credit

Friday, Oct 28/ 8:30-11:30 pm

Round Table Discussion of Unusual Diagnostic and Treatment Problems

Moderator: Paul Gottschalk, MD, Pres.

Sat: Oct 29/ 9:00-3:30 pm

9:00 *Benign Myoclonus of Infancy*
Ivan Stanko, MD, Wausau

9:30 *Subacute Spongiform Encephalopathy: Electroencephalography Light Microscopy and Electron Microscopy in Two Cases*
Phillip M Green, MD, Marshfield

10:00 Coffee Break

10:20 *Ataxia-Telangiectasis, Immunologic Defect and Immune Complex Disease*
C W Hambrook, MD, Rockford

10:50 *Ophthalmoplegic Migraine In Childhood*
William C Robertson, MD, Madison
Eugene R Schnitzler, MD, Madison

11:20 *Cerebrospinal Fluid Cytomorphology*
Robert W Page, MD, Marshfield

11:50 Lunch

1:30 *Evoked Potentials and Their Use In Clinical Neurology*
Guest Speaker: Sanford Larson, MD, Professor of Neurosurgery, Medical College of Wisconsin, Milwaukee

2:30 *Unusual Autopsy Findings In A Case of Peroneal Muscular Atrophy (Charcot-Marie-Tooth-Disease)*
A R Sulaiman, MB, FRCP, (C),
Robert E Koenig, MD
David C Mountain, MD, Milwaukee

2:50 *The Association of Carcinomatous Sensorimotor Polyneuropathy, Midline Cerebellar Degeneration And Myasthenic Syndrome: A Case Presentation*
Thomas J Zweifel, DO and James W Albers, MD, PhD, Milwaukee

3:10 *Human Botulism; Report of Seven Cases Occurring In Three Outbreaks*
Robert W Graebner, MD, Madison

3:30 *The Interaction of Visual And Auditory Evoked Responses*
M Fischer-Williams, MD, FRCP, Milwaukee

3:50 Business Meeting
Paul Gottschalk, MD, President

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

Medical College of Wisconsin

Winter Refresher Course for Family Physicians

Thurs-Fri-Sat/Jan 19-20-21, 1978
Pfister Hotel & Tower/Milwaukee

Two and one-half days. AMA Physician's Recognition Award, 16-18 credit hours. AAFP, 16-18 credit hours.

Course director: Thomas F Garland, MD, Associate Professor of Family Practice, and Program Director, Family Practice Residency Program, Deaconess Hospital.

Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians.

* * *

Further details: Dept of Family Practice, MCW, 610 North 19th St, Milwaukee, Wis 53233.

1977 WISCONSIN

Oct 25-28: *Wisconsin Hospital Association* Convention, Hotel, Pfister, Milwaukee.

Oct 28: *Hospital Cost Dilemma,* Wisconson Hospital Association Convention, Hotel Pfister, Milwaukee.

Oct 28-29: *Wisconsin Neurological Society* meeting, Heidel House, Green Lake. Details elsewhere in this issue.

Nov 12: *Current Advances in Diagnosis and Treatment.* St Joseph's Hospital Clinic Day, Milwaukee, Wis. Guest speakers, Drs Jay Sanford and Jack McGiff. Info: Thomas P Driscoll, MD, St Joseph's Hospital, 5000 W Chambers St, Milwaukee, Wis 53210.

Nov 16: *Green Bay One-day Seminar for Family Physicians,* at St Vincent Hospital. Further details later.

Nov 16: *Colon and Rectal Cancer Program,* St Joseph's Hospital, Chippewa Falls. Details elsewhere in this issue.

Nov 16: *Colon and Rectal Cancer Program,* Howard Young Medical Center, Woodruff. Details elsewhere in this issue.

Nov 18: Medical-Legal-Industrial Symposium of Mount Sinai Medical Center, Milwaukee, at the Pfister Hotel, Milwaukee. Further details elsewhere in this issue.

Nov 30: *Colon and Rectal Cancer Program,* St Clare Hospital, Monroe. Details elsewhere in this issue.

1978 WISCONSIN

Jan 19-21: *Winter Refresher Course for Family Physicians.* Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians. Pfister Hotel and Tower, Milwaukee.

1977-1978 Madison In-Depth Teaching Programs

Preliminary Schedule

Dec 14, 1977—(Wednesday) Madison General Hospital—(changed from Dec 21, 1977)

Jan 19, 1978—(Thursday) St Marys Hospital Medical Center

Feb 15, 1978—(Wednesday) Methodist Hospital

Mar 16, 1978—(Thursday) University Hospitals—(changed from Nov 17, 1977)

1978 WISCONSIN

Jan 28-29: St Mary's Hospital International Burn Symposium, Milwaukee. See details elsewhere in this section.

Feb 1-4: *A Comprehensive Approach to Endoscopy,* Medical College of Wisconsin, Milwaukee. Details elsewhere in this issue.

Feb 3: *Cleaning, Disinfection and Maintenance of Endoscopes,* Medical College of Wisconsin, Milwaukee. Details elsewhere in this issue.

Mount Sinai Medical Center Milwaukee

16th Annual

MEDICAL-LEGAL-INDUSTRIAL SYMPOSIUM

Friday, November 18

Pfister Hotel, Milwaukee

What Constitutes an Inability to Return to Usual and Customary Work?

9:00 Welcome: Ben D Marcus, President, Mount Sinai Medical Center

9:05 Introduction: Sidney K Wynn, MD, Symposium Chairman

9:10 Rehabilitation of the Cardiac Patient and Cardiac Surgery—(a) Medical Viewpoint: Donald H Schmidt, MD; (b) Surgical Viewpoint: W Dudley Johnson, MD

9:50 The Psychology of Returning to Work and the Role of the Insurance Company and Worker's Compensation, Roy B Larsen, MD, Wausau

10:45 Subjective Complaints Without Objective Clinical Findings, Ruth Lunn, RN

11:00 The Effect of the Kurschner Case on the Evaluation of Total Disability and Worker's Compensation (pros and cons), Leonard S Zubrensky and Clayton R Hahn, Attorneys

11:30 Questions

12:00 Lunch

1:15 The Rehabilitation Nurse, Colleen Kennedy, RN

1:30 Profiling the Industrial Injured Worker, John W McKay, MS, Neenah

2:00 Problems Dealing in Rehabilitation of Injured Workers, John L Melvin, MD

2:30 Questions

Registration fee: $25, to: Mount Sinai Medical Center, Medical Center Relations, PO Box 342, Milwaukee, Wis 53201.

A COMPREHENSIVE APPROACH TO ENDOSCOPY

6th Annual Endoscopy Conference

Sponsored by Section of Gastroenterology, The Medical College of Wisconsin

February 1-4, 1978, Milwaukee

The Medical College of Wisconsin's annual mid-winter endoscopy conference has gained recognition for its innovative and critical presentation of the teaching and interpretation of endoscopic techniques. In keeping with this tradition, a 3-day seminar on *A Comprehensive Approach to Endoscopy* will emphasize the latest advances in diagnosis, therapy and instrumentation.

An outstanding guest-faculty will discuss and demonstrate endoscopic techniques through lectures, case presentation and model demonstrations.

Small group discussion sessions will offer interaction between the faculty and the participants.

Guest Faculty

H Worth Boyce, MD, Tampa, Fla

Thomas Ihre, MD, Stockholm, Sweden

James W Manier, MD, Marshfield

John F Morrissey, MD, Madison

Jack A Vennes, Minneapolis, Minn

Jerome D Waye, MD, New York

Christopher B Williams, BM, MRCP, London, England

The Medical College of Wisconsin Faculty.

20 AMA Category I credits applied for.

Info: Joseph E Geenen, MD, or Walter J Hogan, MD, G I Section, 8700 W Wisconsin Ave, Milwaukee, Wis 53226.

Tel: 414/257-6047

University of Wisconsin-Madison Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

CME Calendar—1977-1978

Nov 16: *Maternal and Infant Care: Special Neonatal Problems II,* Beaver Dam Community Hospitals, Beaver Dam.

Dec 21: *Maternal and Infant Care: Optional Assessment of Series,* Beaver Dam Community Hospital, Beaver Dam.

Jan. 10: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Feb. 8: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Feb 14: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Mar 14: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Apr 11: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Apr 11-12: *Patient Education,* The Concourse Hotel, Madison.

Apr 13-15: *Seminar-Workshop in Radiology,* The Wisconsin Center, Madison.

Apr 21-22: *Conference on Dermatology,* The Wisconsin Center, Madison.

Info: Coordinator, Dept of CME, 601 Walnut Street, Madison, Wis 53706; phone: 608/263-2850.

COLON AND RECTAL CANCER PROGRAM

Sponsored by American Cancer Society-Wisconsin Division, Inc; University of Wisconsin-Madison Department of Continuing Medical Education; and Wisconsin Clinical Cancer Center

CHIPPEWA, FALLS, November 16, St Joseph's Hospital, registration 8:30 am, program 9:00 am - 12:00 noon

WOODRUFF, November 16, Howard Young Medical Center, registration 1:30 pm, program 2:00 pm - 5:00 pm

MONROE, November 30, St Clare Hospital, registration 8:30 am, program 9:00 am - 12:30 pm

TOPICS: *Colon-Rectal Cancer Etiology,* Edward Balish, PhD, Professor of Surgery, University of Wisconsin, Madison; *Diagnosis and Surgical Management,* William Wolberg, MD, Professor, Human Oncology, UW-Madison; *Role of Radiation Therapy and Chemotherapy in Management,* Ernest Borden, MD, Assistant Professor, Medical Oncology, UW-Madison.

COST: $5.00 per person (includes meal); registration to: American Cancer Society-Wisconsin Division Inc, PO Box 1626, Madison, Wis 53701. Cancellations accepted until November 11.

METHODS OF BURN TREATMENT

Second International Burn Symposium of St Mary's Hospital, Milwaukee

January 28-29, 1978

Co-chairmen: Burton A Waisbren, MD, Director of the Burn Research and Clinical Paradigm Laboratory and Associate Director of the Burn Center; and George E Collentine, Jr, MD, Director of St Mary's Burn Center.

Proof of Efficacy of Methods of Burn Treatment—Alternate Pathways will be the subject of the two-day session in which the foremost international burn surgeons will be allowed to present a specific method of burn treatment to an expert panel of critiquers, who will analyze the results. The audience will also be allowed to critique the presentations.

Presenters:

—**William F Monafo, MD,** Dept of Surgery, St John's Mercy Medical Center, St Louis, Mo.

—**Burton A Waisbren, MD,** St Mary's Burn Center.

—**George B Hart, MD,** Long Beach Hyperbaric Center, Long Beach, Calif.

—**John F Burke, MD,** Shriners Burns Institute, Boston, Mass.

—**Bent Sorensen, MD,** Professor of Surgery, University of Copenhagen, Denmark.

—**J Wesley Alexander, MD,** Shriners Burns Institute, Cincinnati, Ohio.

—**Irving Feller, MD,** University of Michigan Burn Center, Ann Arbor.

The first St Mary's Symposium dealt with the issue of skin banking. The objective of this session is to help those engaged in the treatment of burns to decide whether there is enough evidence for them to justify the use of the new modalities being discussed. Furthermore, the intimate exposure with the foremost experts on experimental design in this country will allow them to more scientifically evaluate and present new methods of treatment that they may develop.

For additional information contact Peter Hanson or Mary Sparks, 414/289-7144 at St Mary's Hospital, Community Relations Department, Milwaukee, 2323 North Lake Drive, PO Box 503, Milwaukee, Wis 53201.

Meetings of the American COLLEGE OF SURGEONS

CLINICAL CONGRESSES

1978: Oct 16-20—San Francisco
1979: Oct 22-26—Chicago
1980: Oct 20-24—Atlanta

SPRING MEETINGS

1978: Mar 13-16—Cincinnati
1979: Apr 2-5—Denver
1980: Mar 24-27—Toronto

Info:
American College of Surgeons
55 Erie St East, Chicago, Ill
60611

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

October 31 - November 13
A Clinical Approach to the Major Motor Disorder of the Esophagus is a two-part presentation with R D Henderson, MB, FRCS, Chief of Surgery, Women's College Hospital, Toronto; and Associate Professor of Surgery, University of Toronto, Canada.

Informed Consent: Malignant or Benign? with Kevin M McIntyre, MD, JD, Associate Professor of Medicine, Harvard University Medical School, and Assistant Chief of Cardiology, West Roxbury Veterans Administration Hospital, Boston.

November 14 - November 27
Electromyographic Testing for Neuromuscular and Other Diseases with David Campion, MD, UCLA Institute of Rehabilitation and Chronic Diseases, Los Angeles.

Criteria for Elective Plastic Surgery with Edgar P Berry, MD, Chief of Plastic Surgery, Lenox Hill Hospital, New York.

Arthritis in Childhood with Bernhard H Singsen, MD, Pediatric Rheumatology Children's Hospital of Los Angeles.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic videocassettes and half-inch Betamax formats.

1978 WISCONSIN

Mar 30-Apr 1: Second Annual Ophthalmology Current Concepts Seminar '78 of the University of Wisconsin-Madison. Lectures and Workshops. Sponsored by the Dept of Ophthalmology Faculty, University Hospitals, Madison.

1977 AMA

Nov 10-11: AMA 16th National Conference on Physicians and Schools, Regency Chicago, Chicago.

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Dec 20-23: AMA National Leadership Conference.

Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

1978 OTHERS

Jan 28-29: Second International Glaucoma Congress, at Americana Hotel in Miami Beach, Fla. Being held in conjunction with Annual Scientific Assembly of American Society of Contemporary Ophthalmology, Jan 30-Feb 3. Info: Dr John Bellows, Director, 6 North Michigan Ave, Chicago, Ill 60602. g8-12/77

CLEANING, DISINFECTION AND MAINTENANCE OF ENDOSCOPES

GI Assistants course sponsored by the Section of Gastroenterology The Medical College of Wisconsin

February 3, 1978, Milwaukee, Wis

This seminar will deal with the prevalence and prevention of infectious diseases in the endoscopy unit, cleaning and basic maintenance of endoscopes and endoscopic equipment.

Participating in the presentations and discussions will be a microbacteriologist, an epidemiologist, endoscopy nurses and representatives of instrument and pharmaceutical companies.

This course is being held in conjunction with the 6th Annual Endoscopy Conference for Physicians, sponsored by the Medical College of Wisconsin, February 1-4, 1978.

Registration fee: $75

Info: Ms Marcis Pfeifer, RN, Course Director, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406

1978 OTHERS

Jan 30-Feb 3: Annual Scientific Assembly of American Society of Contemporary Medicine and Surgery, at Americana Hotel in Miami Beach, Fla. Meets criteria for 40 hours of credit in Category I for AMA-PRA. Info: John G Bellows, MD, PhD, Director, 6 North Michigan Ave, Chicago, Ill 60602; (312) 236-4673.
g8-12/77

Mar 29-31: *Diagnostic and Therapeutic Advances in Gastroenterology*, American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Oct 17-21: *Medical Knowledge Self-Assessment Program Course*, Hyatt Regency, New Orleans, La. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa 19104.

CONTRIBUTIONS—CES FOUNDATION
August 1977

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for August 1977.

Restricted

Hayward Medical Group; Dodgeville Clinic; Wisconsin Physicians Service; Putnam Heights Clinic, Eau Claire—*Medical Student Summer Externship Program*
Benjamin W Louthan, MD—*Academy of Medical History Dues*
Membership Dues—*Aesculapian Society*

Memorials

Dr-Mrs Robert Schmidt—*Julia Kohl; John H. Hughes; Charles Egan; Glen Denys, MD (Brown County Loan Fund)*
NMC Projects, Inc.—*E E Bryant (E E Bryant Memorial Fund)*
Mrs Robert W Burns—*Mr Harry L Conley*
Mr-Mrs Earl R Thayer—*Harvey H Kitzman; Sister & Husband of Edward Collins*
Paul G LaBissoniere, MD—*Mr Oscar Mitzenheim*
Charles J Picard, MD—*William J Egan, MD*
EJ Nordby, MD—*Evelyn Lipp, MD*
The Stafford Family—*Joanne Harris*
Barbara and Howard Brower—*Mildred (Mrs George F Sr) Lull*
State Medical Society—*John Albino, MD; Richard J Dietz, MD; Walter C Andrews, MD* ■

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I certify that the statements made by me are correct and complete.
/s/ MARY ANGELL
Assistant Managing Editor
Date of filing: Sept. 21, 1977
PS Form 3526, modified above for purposes of printing.

1977 Meeting Dates/Sites

NATIONAL MEDICAL SPECIALTY SOCIETIES

Oct 30-31: American College of Preventive Medicine, Atlanta, Ga, Annual.

Oct 30-Nov 4: American College of Chest Physicians, Las Vegas, Nev, Annual.

Oct 30-Nov 4: American Congress of Rehabilitation Medicine, Miami, Fla, Annual.

Oct 30-Nov 4: American Society of Plastic and Reconstruction Surgeons, Inc, San Francisco, Calif, Annual.

Oct 31-Nov 4: American Association of Public Health Physicians, District of Columbia, Annual.

Nov 5-10: American Academy of Pediatrics, New York, NY, Annual

Nov 8-10: College of Emergency Physicians, San Francisco, Calif, Annual.

Dec 3-8: American Academy of Dermatology, Dallas, Tex, Annual.

THE FINANCING OF MEDICAL CARE

10th Annual Workshop of the Institute of Medicine of Chicago

Continental Plaza Hotel, Chicago

Friday, November 11

8:00 am to 5:00 pm

Are consumer health care demands realistic in terms of actual health care needs?

How Will Rising costs in the financing of health care affect undergraduate and graduate medical education?

Governmental, academic and private insurance company solutions to these problems will be subjects for panel and general discussion along with advantages and disadvantages of "capping" hospital payments and other means of cost containment in every phase of health care.

Registration ($45 for nonmembers, $40 for members) includes luncheon and coffee breaks.

For information, write Institute of Medicine of Chicago, 332 South Michigan Ave, Chicago, Ill 60604, or call 312/663-0040.

AMA OFFERING SPEAKER TRAINING PROGRAMS

The American Medical Association is sponsoring several Speaker Training Programs in 1978. Three Spokesmanship Seminars at the Chicago Marriott O'Hare Hotel are being offered to physicians and medical executives who officially represent their organizations via the print or broadcast media. The seminars are scheduled for March 4-5, 1978; August 5-6, 1978; and November 25-26, 1978. *Physicians also may arrange to have a seminar tailored to and presented in their own states or county medical societies.*

The AMA also is offering Public Speaking Seminars consisting of lectures and practical exercises which deal with the public communications problems physicians often face. The seminars emphasize speech preparation, delivery, use of visual aids, handling questions, techniques on panel participation and personal evaluation through videotape playbacks. The seminars are scheduled during the AMA National Leadership Conference on January 26, 1978 at the Chicago Marriott O'Hare Hotel and during the AMA Regional Meeting on April 15-16, 1978 in Detroit, Michigan. To obtain more information about either the Spokesmanship Seminars or the Public Speaking Seminars, *or to schedule a Spokesmanship Seminar in your area,* interested physicians should contact Mr. Mortimer Enright at the AMA, 535 N Dearborn St, Chicago, Illinois 60610, tel 312/715-6452.

BOOKLET: CROSSROADS—HEALTH CARE FOR RURAL WISCONSIN

The SMS Charitable, Educational and Scientific Foundation has funded reprinting of the booklet, "Crossroads—Health Care for Rural Wisconsin," as a service to the public. The booklet, first published in June 1976 by the Health Resource Committee, a joint committee of the State Medical Society and the State Health Policy Council, is designed to offer guidelines for action to communities seeking to improve their primary care services and to be used as a reference tool to locate and utilize local, state, and federal sources of the necessary specialized information and assistance. For in-state organizations there is no charge for 5 copies or less; over that, the cost is $1.00/copy. Out-of-state requests will be $1.00/copy, including postage. Requests can be directed to: Bill Wendle, Coordinator, Continuing Medical Education, SMS/CESF, Box 1109, Madison, Wis 53701 (checks payable to CES Foundation).

AMA COMPUTER CONSULTATIVE SERVICES PROGRAM

As a new service, the American Medical Association is now offering individualized consultation for computer systems in physicians' medical practices. The "Computer Systems in Medicine Consultative Services Program" may be helpful to the physician who is considering incorporating computer capabilities into various phases of his practice, or current users who may want to improve or expand their computer applications. The AMA consultant will evaluate what is feasible and what is desirable for the physician's needs. For more information, physicians should contact John A Guerrieri Jr, Computer Systems in Medicine, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610; tel 312/751-6417.

NEUROLOGICAL SOCIETY TO MEET OCTOBER 28-29, GREEN LAKE

Members of the Wisconsin Neurological Society will meet October 28-29, at the Heidel House in Green Lake for their 19th meeting. The meeting qualifies for Category I credit by AMA-PRA. Further details appear in the YELLOW PAGES section of this issue. ■

DRUGS ADDED TO GENERIC DRUG FORMULARY

The State Department of Health and Social Services has added ten drugs and dropped one drug from the Wisconsin Generic Drug Formulary. Drugs added to the list are: dioctyl sodium sulfosuccinate, a laxative; chloral hydrate, a sedative; chlorothiazide, a diuretic; isoniazid, a drug used to combat tuberculosis; oxytetracycline, an antibiotic; propoxyphene, an analgesic; propylthiouracil, a drug used to treat hyperthyroidism; reserpine, a drug used in treating hypertension; sulfisoxazole, an antibiotic; and trisulfapyrimidine, an antibiotic. Doxepin, an antidepressant, was dropped from the formulary, since only two companies manufacture the drug.

GOVERNOR SIGNS PROFESSIONAL LIABILITY LAW

Acting Governor Schreiber signed AB 704 into law October 25. The bill was developed by the Legislature's Interim Malpractice Committee and was strongly supported by the Physicians Alliance Division of the State Medical Society. Physicians Alliance commissioner Frederick Kriss, MD of Madison served on that interim committee. AB 704 makes a number of technical changes in the 1975 law, including clarifying malpractice panel membership and permitting the state liability plan to write a second "layer" of insurance coverage ($100,000-$300,000).

OCCUPATIONAL LICENSING PROPOSAL RECEIVES "PUBLIC" AIRING

The state public radio network featured a discussion of proposed changes in licensing laws in Wisconsin on Sunday, October 30. The program, which was carried live over all state educational radio stations, featured legislators and other individuals interested in the 1977 Assembly Bill 784. AB 784 proposes to establish a "superboard" for the control and regulation of all professions and occupations, including medicine, in Wisconsin. The program gave citizens, including physicians, an opportunity to call in questions to the panel members.

HEW TO INVESTIGATE MEDICAID FRAUD IN WISCONSIN

The Department of Health, Education, and Welfare recently announced its plans to investigate 25 pharmacists and 25 physicians in Wisconsin for possible Medicaid fraud. A computer check made by the HEW of State Medicaid records disclosed a pattern of excessive or unusual Medicaid payments in the 50 cases. The investigation in Wisconsin is part of a nationwide investigation of Medicaid fraud labeled "Project Integrity." HEW officials said that no names will be released unless criminal indictments are handed down. Medicaid fraud amounts to $900 million a year according to the Department.

INMATES AT COUNTY JAILS RECEIVE PHYSICAL EXAMS

Inmates at the Eau Claire, Adams, and Milwaukee County Jails recently received complete physical examinations as part of the continuing Jail Health Program conducted by the State Medical Society of Wisconsin. The Milwaukee and Eau Claire jails recently were among the first correctional facilities to receive accreditation for meeting standards of the Jail Health Program. All of the participating inmates volunteered to receive the physical examinations and each signed a consent form. Volunteer physicians administered the actual physicals, while volunteer nurses took the inmates' oral history, weight, height, and blood pressure readings, and volunteer laboratory technicians took blood samples. Through the physicals, the Society will assess previously undetected health problems of the inmates and suggest changes in health-care procedures, if any are necessary. The State Medical Society wishes to thank all the volunteer physicians, nurses, and laboratory technicians for their contributions to the program. ■

the wisconsin medical journal

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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Council powers

PASSAGE OF certificate-of-need legislation in Wisconsin this summer was made possible through negotiations between leadership of the State Medical Society, representatives of the State Department of Health and Social Services, and the Legislature. The Council lent its support to the new law after a special briefing session last spring at which the entire matter was reviewed in light of current developments. The action was taken in spite of a previous House of Delegates' decision against certificate-of-need.

Several members of the Society have since complained to their councilors stating that the Council had no right to countermand an action of the House. These complaints are not justified. The Constitution of the State Medical Society states in Article VI that: "The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws."

The House of Delegates, meeting as it does only once a year, cannot possibly foresee the changes in the ensuing months that might bear on its deliberations; hence the establishment in Article VI, granting the power of the House of Delegates to the Council which meets frequently and can respond to changes more appropriately. On certificate-of-need the Council acted wisely and responsibly.—WJB

Wrestling and weight control

HIGH SCHOOL WRESTLING has become increasingly popular in Wisconsin. However, there is one aspect of the competition that concerns physicians. This is the problem resulting because some of the high school boys seem to think it is desirable to wrestle in the lowest possible weight class

High schools must certify minimum weights for their boys by December 15. By February 1 a gain of no more than three pounds is permitted. The Wisconsin Interscholastic Athletic Association (WIAA) enforces weight certification and attempts to discourage coaches from keeping boys out of early competition in order to put them through a weight-reduction program and qualify them for a lower weight classification. Any wrestler is allowed to move up to a new weight class, but this is considered highly undesirable by the young contestants.

According to a report of the Board of Trustees of the AMA, there are charges that ill-advised and medically hazardous methods of weight control are being practiced. Allegedly some wrestling coaches are requiring growing boys to attain and maintain for the season certified weights considerably below their optimum weight. This has been accomplished by crash diets, by the use of fluid restriction resulting in dehydration, and the use of diuretics, rubber suits, sweat boxes and even vigorous gum chewing to stimulate salivation.

The AMA Committee on Medical Aspects of Sports has prepared a report indicating that any form of dehydration will impair performance for a wrestler. Water deficiency causes premature fatigue and eventually clinical illness. The report continues that professional judgment would best be exercised if coach and physician take as their objective the boy's effective weight level instead of a minimal weight level. For any athlete there is no alternative to a balanced diet at a sustaining caloric level, adequate fluid intake, and high-energy output for attaining and maintaining an effective competitive weight.

Although the extreme abuses noted above have not been reported in Wisconsin, I recall seeing a young man towards the end of the wrestling season who came in complaining of complete exhaustion as a result of stringent dieting and fluid loss. His wrestling career was terminated then and there. He slept most of the time for the next 48 hours, only waking up at intervals to eat ravenously. He made a remarkable recovery.—VSF ■

Is it worth it?

AGONIZING ALONG with a son in premedical training as he awaits his acceptance by a medical school can be an unsettling experience. What should a parent's attitude be? It must be supportive, of course, but should a boy be encouraged to go on and perhaps waste several years taking courses his advisor thinks he will need to pass the MCAT if his grade point average hovers around the 3.5 or 3.6 mark? If you do choose to encourage him, how should you react as the H-hour draws near and he still hasn't been accepted? If you take the positive approach and assume to the last that he will be

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accepted, will rejection, if it comes, be too great a blow for him and for you?

Or should you hedge your bets and condition him for possible rejection by expounding the sour grapes concept that medicine isn't what it used to be anyway —that its image has been tarnished by the Medicaid cheaters and the new breed who don't like to get out of bed at 3:00 am to deliver a baby—that maybe he would be just as happy teaching biology or running a business if he isn't accepted by the Class of '81?

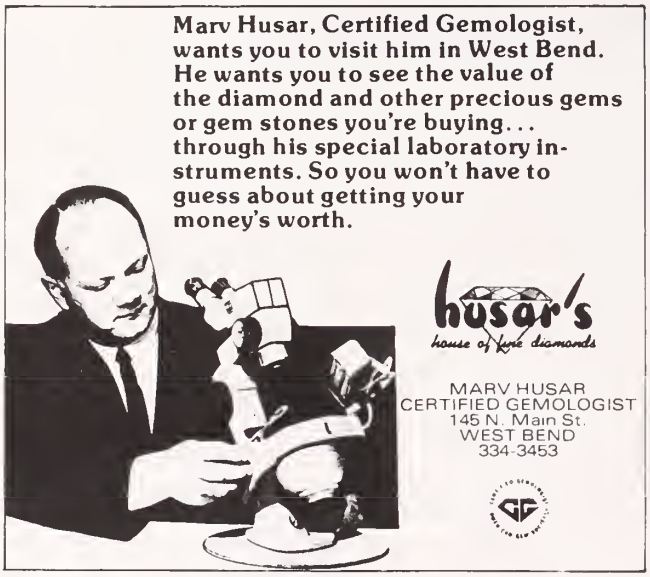
I guess what we really have to ask ourselves is: Is it worth it anymore? Have the changes in the practice of medicine brought about by third-party intervention and other influences really been substantive changes—changes which would make you change your mind about going to medical school if you had to make the decision in 1977? Are the anxious, highly competitive years in premedical school, the expensive, grueling four years of medical school, and the added postgraduate years of additional sacrifice too high a price to pay for the right to practice a profession which for many reasons may not be what it once was?

Looking back on my own practice and thinking about what has happened since I first hung out my shingle, I find the question very easy to answer because I don't think medicine has changed in a substantive way. A difficult diagnosis, correctly made, is still exciting, even though technology has made it easier than it was. A well-executed surgical procedure, resulting in the prolongation of a useful life, and returning a mother or a child to a grateful family is a thrill undiminished by government regulatory agencies and insurance forms. Perhaps most important of all, medicine is just as challenging and new today as it was a generation ago.

If you're the type who must work long hours and are unhappy unless you go home dog-tired everyday, there are still all kinds of places where you will be welcome. Inevitably, in spite of everything, we still fail occasionally, but failure can be satisfying, too, if we know that we have given something of ourselves in a wholehearted attempt to aid someone who has come to us for help. And finally, the most pessimistic of our colleagues would have to admit that when it comes to job security, medicine ranks high.

So obviously I do think it's worth it, and I would not have sounded very sincere if I took the approach with my son that failure to get into medical school might be a blessing in disguise.

Fortunately, I didn't have to.—WJB



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A dangerous trend—legislators practicing political medicine

IN THE FANTASY of all fantasies, *The Wizard of Oz,* the heroine Dorothy at one part remarks to her canine companion, "Toto, I have a feeling we're not in Kansas anymore."

At times, the deliberations of the Commission on Governmental Affairs of the State Medical Society over recent legislative proposals cause one to wonder whether we too have left "Kansas" (read Wisconsin!) and journeyed to The Land of Oz.

LUBITZ

The history of government involvement in the entire health-care system is at least partially comprehensible when the issues of medicare/medicaid, certificate-of-need, or catastrophic health insurance are debated. The feeling that fantasy rather than reality controls the "legislative process" surfaces whenever we examine the growing tendency of legislatures everywhere to practice medicine rather than politics.

When I speak of a legislature "practicing medicine," I am not referring to certificate-of-need or T-19 regulations and the like. Rather I am speaking of a growing and dangerous trend on the part of legislators and others outside medicine to decide, for example, that laetrile or saccharin or drug "X" ought to be made available to the citizens of the state simply because "they" demand it, or need it, or that society ought to provide that "freedom of choice."

The pro-laetrile forces at work in this country choose to ignore the facts about that substance, whether the facts come from the FDA, the AMA, or individual physicians. Rather they make their case on the basis that as long as it is not *proven* harmful, legalization is the *right* of anyone who chooses to use the substance. While that argument may sound ridiculous, it was strong enough to convince a vast majority of the Wisconsin State Assembly to pass legislation legalizing the manufacture, sale, and use of the substance. *Medical* facts were not important; emotion and hysteria about a dangerous disease and a strong political lobby based on some inherent right to its use overpowered the medical facts.

It is this situation that should concern all physicians. The movement towards legislative medicine is not just evident in the area of drugs. The Legislature recently saw fit to mandate infant tests for a series of metabolic disorders because of high incidence rates of the diseases. This occurred in spite of the questionable validity of such tests when administered prior to the discharge of the infant from the hospital—a *current* medical "fact" which causes physicians to often administer a second series of tests on the infant after several weeks of life, at a time when the tests are of some significance. Incredible as it may sound, many legislators agreed with the State Medical Society when it said that tests should be considered one-by-one by a panel of medical experts rather than via a carte blanche test requirement. However, the bill was seen as a "political" solution to the problem, designed to force the State Division of Health to conduct tests although it currently has the authority to force the tests to be undertaken.

With the recent passage of a bill to "equalize" physicians and chiropractors in health-care insurance plans, the Legislature made the determination that physicians and chiropractors provide "significant contributions to health care." This is perhaps the most significant insult to medicine as a profession given the highly questionable basis for chiropractic care. Once again, the "right" to choice and an effective lobby allowed (or forced) the Legislature to practice political medicine.

A recent medical case has led to yet another example of political medicine. Following a decision by a Dane County judge on the "death" of an individual suffering from massive brain damage, several legislators are contemplating measures to define death. The idea is that physicians somehow need statutory guidance on the definition of death. Physicians have, and continue to deal with this "question" every day; is there truly an advantage or need, for legislative guidance on this issue? Whether or not one answers that question in the affirmative, additional questions and concerns arise that make such a determination complex and controversial. Again, input from physicians is critical and probably will not be forthcoming unless we as physicians make the initial contact with legislators.

The State Medical Society through the Commission on Governmental Affairs is deeply concerned about this trend toward medical decisions being made in the political arena. All of the above

legislative efforts were strongly opposed by the Society. Some of these efforts by the State Medical Society were obviously more successful than others. However, this concern must somehow filter into every quarter of medicine, to every physician, and to everyone who cares about *quality* medical care. Without that, the Legislature may soon make all of those decisions in an arena devoid of medical fact.

As much as "government regulation" is on the minds of every physician, so should be government "deregulation" of the types of care, services, and substances made available to our citizens. Without the voice of medicine and its component physicians assuming a strong posture in this area, Wisconsin could become a "Land of Oz."

JOSEPH M. LUBITZ, MD
Oconomowoc ■

NOTE: The next IN PERSPECTIVE will feature efforts of the Committee on Federal Legislation, which is chaired by Robert F Purtell, Jr, MD

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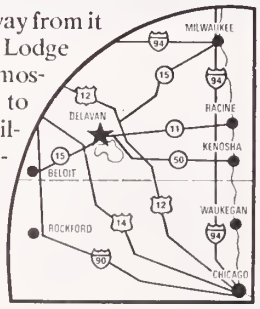

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A QUARTERLY COMMUNICATION TO PHYSICIANS NOVEMBER 1977

An advisor speaks

Raymond M Baldwin, MD, Beloit

OVER TWENTY YEARS ago I was asked to be an advisor to a newly formed association of young women who had taken the official name of the American Association of Medical Assistants, which was composed of young women who worked for a Doctor of Medicine. They might be secretaries or bookkeepers or receptionists or nurses working in the treatment room, laboratory technicians or x-ray technicians or what we at that time called our "office girls." Many of them were hired directly from high school with no formal training whatsoever, not even typing. They were supposed to keep the office clean, the doctor's white coats ready and as was the case of the majority of them they were not specialists, they were to unquestioningly do what the doctor ordered and keep their eyes and ears open and their mouths shut. They fixed a cup of coffee for the doctor, ran his errands, got his cigars at the corner drug store, and even occasionally mended his coats or sewed a button on his shirt, kept his appointments, did his banking, drove him on some of his house calls and helped in any way possible. Believe me, this is the way it was.

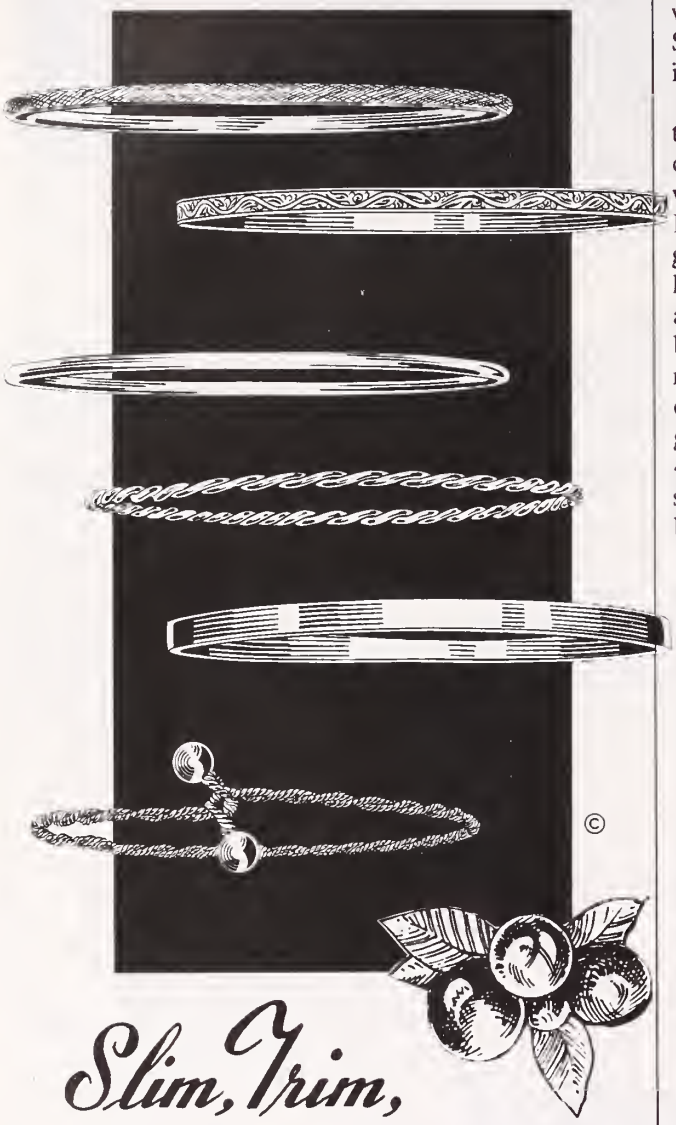
By 1954 clinics were forming or had been formed where the "office girls" specialized and became secretaries, receptionists, laboratory or x-ray technicians, assistants in minor surgery, and were even giving medications both oral and parenteral on their doctor's orders. Other than the nurses and some x-ray and laboratory technicians, they had no formal training but were trained by the doctor or by another medical assistant working in the doctor's office. They were a loyal, and for the most part, dedicated group of individuals, who chose this type of work, not so much for the money which they could make, but more because they had an inborn desire to help people and they felt the need for more knowledge to better serve their doctor and his patients.

Medical practice was rapidly changing and the era of specialization was developing; even the general practitioner began restricting his practice to those things that he would like to do; avoiding or referring the cases that he did not want. The "one girl office" was decreasing in numbers with doctors finding it more expeditious to hire a secretary and a nurse or technician and most of all, the demand had arisen for applicants trained in various skills common to a doctor's office practice. It is understandable then that this new organization, the American Association of Medical Assistants, as it was being formed in 1955 placed a great emphasis on education as one of the reasons for its being. As a result of this demand for trained assistants, schools had been started in many parts of the country; a few were good, many inadequate. None gave any course or instruction that would take the place of experience in a doctor's office.

The American Association of Medical Assistants was composed of individuals with varying degrees of experience, training and competence, all working under the direction of a doctor in an office or a clinic. They recognized the inadequacy of the schools that were training girls to become medical assistants. So, with the help of the Education Council of the American Medical Association and with the cooperation of educators in colleges and schools and with the help of money grants from a few sources interested in the advancement of education of medical assistants, an educational program was set up, national in scope to give advice and direction and recognition to those schools seeking to teach medical assistants. And in order to give recognition to those individuals who sought to increase their knowledge by attending these schools, a program of certification was developed which consisted of strict rules in regard to both education and experience and an examination was given. This examination was very comprehensive, difficult but fair, and placed a stamp of excellence and achievement on those who passed it. Anyone working in a doctor's office can be a medical assistant; any medical assistant can become a member of the medical assistants society, but only those who pass the rigorous examination can become a Certified Medical Assistant and proudly wear the pin "CMA," category one or two or both, and above all have that sense of achievement and the knowledge that they are keeping up

with the team as a professional in the doctor's office. She does not replace the doctor or the nurse but she is one of the team.

But the practice of medicine has not remained stationary, so in addition, just as the doctor has had to continue with his education to stay up with the advancement in medicine, so must the medical assistant. It is my belief that in the near future, now with the government's fingers reaching into every part of our lives, that certification may be required for all medical assistants and that certification will not be the end, but that the continual obtaining of educational credits may be necessary to keep the certification valid. The emphasis is on education. The AAMA has done a good job. There were 24 CMAs in 1963 and over 4,000 in 1976. Let's all get behind the medical assistants certification program and build a bigger and better medical community and keep it that way. ■



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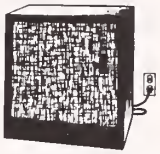

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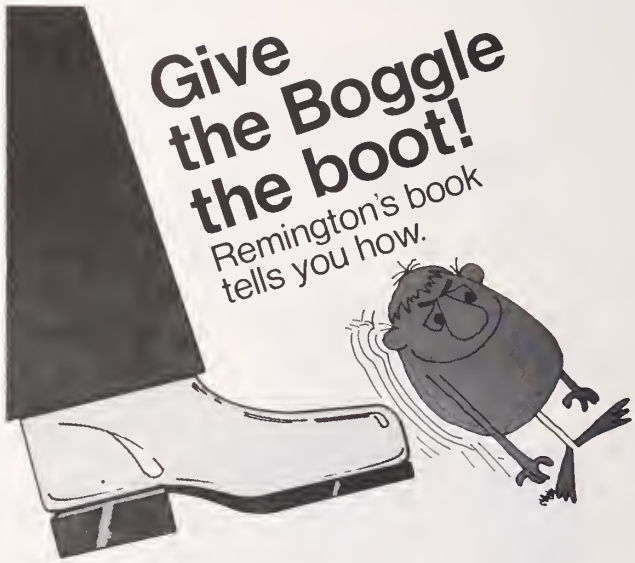
Medical Examining Board bans most uses of amphetamines

Effective November 1, 1977 virtually all sales and prescriptions of amphetamines were banned in Wisconsin in an action taken by the State Medical Examining Board. The Board added the new rule to the section in the Wisconsin Administrative Code, Chapter 10.02 (2) (s), which defines unprofessional conduct to include:

"Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine drug or compound or derivative, congener or analogue thereof to or for any person except for the treatment of narcolepsy, or for the treatment of hyperkinesis, or for the treatment of drug-induced brain dysfunction, or for the differential diagnostic psychiatric evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun."

Violation of this rule could result in discipline, including loss of license.

The State Medical Society is reemphasizing its position that physicians limit the prescribing and dispensing of amphetamines to recognized conditions where these drugs are indicated. ■



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*National Disease & Therapeutic Index, Jan.-Dec., 1976. IMS America Ltd., Ambler, Pa. 1976.
†Amer. Med. Assn., Dept. of Drugs, A.M.A. Drug Evaluations, 2nd Edition, Publishing Sciences Group, Inc., Acton, Mass., 1973, pp. 482-3.

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Radiation risk in mammography

THE BEST DETECTORS of breast carcinoma have been patients who accidentally discovered a breast lump. The average diameter of these self-discovered tumors is 3.5 cm. Tumors this large have axillary node metastases 65% of the time. Of these patients only 40-50% survive five years and 25% ten years. These figures indicate why the death rate for patients with breast cancer in the United States has remained stable for 40 years with about 35,000 deaths per year. Only about 45% of patients with regional lymphatic node metastases can be cured.

Fortunately, because of better informed doctors and patients, plus tremendous improvements in mammographic techniques, we are on the verge of dramatically increasing the number of breast carcinoma patients who can be cured and decreasing the death rate. With better public education, the number of women practicing self-examination and having annual clinical examinations has increased. With improved medical education, physicians now suspect cancer more often and consult cancer specialists earlier.

Teamwork among physicians is absolutely essential in order to find breast malignancies. Close consultation between referring physician or surgeon, radiologist, and pathologist is mandatory for diagnosis of minimal breast carcinoma. Patients who have breast lesions 1 cm or less that are not symptomatic or palpable and who have negative axilla are potentially curable. Premalignant lesions exist and should be closely followed. Recent improvements in the use of film mammography, xeroradiography, and especially negative xerography have made it possible to detect clinically occult breast cancers by detecting maligant calcifications with minimal or no tumor, regardless of position. During 1976 more than 50% of all the mastectomies performed at the University of Wisconsin Hospitals were for clinically occult carcinomas.

In the past clinical information alone warranted risk evaluation for breast carcinoma; however, Wolfe[1] recently reported that the radiographic appearance of breast parenchyma may provide a way to predict who will develop breast cancer. He placed patients in four risk categories for developing breast carcinoma on the basis of their radiographic breast pattern. (Patients over 40 do not change their breast pattern.) There was a 37 times greater incidence of malignancy in the highest risk group compared to the lowest risk group. These classifications, used with clinical evaluations, are of value in everyday practice of mammography in women 40 and over.

Recently mammography has been attacked because of Dr John Bailar's article,[2] which stated that patients who had received large doses of radiation had increased incidence of breast carcinoma. Using linear extrapolation, Doctor Bailar concluded that radiation exposure may be causing more breast cancer than is being found. He presented his information as fact rather than hypothesis, despite the warning of the National Council of Radiation Protection and Measurement[3] against using linear extrapolation from high to low dose. The Council stated that "there is such a high probability of overestimating the actual risk as to be of marginal value, if any, for purposes of realistic risk-benefit evaluation." Most importantly the clinical studies used were outdated and did not represent the cancer-finding potential of mammography. Indeed, the Health Insurance Program of Greater New York study which Doctor Bailar used showed no improvement in mortality of patients under 50. Recently Dr Lester Breslow[4] combined hypothetical radiation risk with this information and reached the same conclusion: that there should be no screening of women under 50 years of age, although any woman who has a clinical problem or family history of cancer should have mammograms as needed.

The highest incidence of in situ carcinomas occurs from 40 to 50 years of age and of infiltrating carcinomas after age 50. Recent results from 27 screening programs indicate that of 270,000 women screened, 884 clinically occult carcinomas were detected, of which 223 were in patients under age 50. Of these 100 cases (44.8%) were detected by mammography alone; most were free of axillary nodal metastases.[5]

At the University of Wisconsin Hospitals we believe that physical and mammographic examinations of the breast are complementary and should be considered together in decision-making. The role of mammography is to confirm the physical findings and add information for differential diagnosis. Each mode of evaluation must be considered independently in order to indicate the need for surgical biopsy.

REFERENCES

1. Wolfe JN: Breast patterns as an index of risk for developing breast cancer. *Am J Roentgen* 126:1130-1139, 1976.
2. Bailar JC III: Mammography; a contrary view. *Ann Intern Med* 88:77-84, 1976.
3. National Council of Radiation Protection and Measurement, Bulletin 43, 1975.
4. Breslow L: Progress report submitted to Dr Guy R Newel (National Cancer Institute), July 15, 1976.
5. American College of Radiology Bulletin, Vol. 32(10), October 1976.

—RAUL MATALLANA, MD
Department of Radiology
University of Wisconsin
Center for Health Sciences
Madison, Wisconsin

Dial Access Service renewed

Physicians, dentists, nurses, and students—the Wisconsin Clinical Cancer Center has renewed the Dial Access service which makes over 300 six-to-eight minute tape recordings of recent diagnostic and therapeutic information on specific neoplastic disease problems available to you by calling 1-800-231-6970, toll-free. ■

Cancer column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

HSA PUBLIC HEARINGS ON PROPOSED NATIONAL GUIDELINES HELD

The Health Systems Agencies (HSAs) in Wisconsin held public hearings in Madison and Green Bay earlier this month to discuss the US Department of Health, Education, and Welfare's (HEW) proposed rules establishing national guidelines for health planning. These federal guidelines, if adopted, will become requirements that all HSAs will have to meet in their Health Systems Plans within five years. Failure to meet the requirements within this period may result in a hospital merger, closing, or partial or total changes in services. Hospitals under 100 beds and in rural areas will be particularly hard hit by the requirements. The national guidelines include the following:

—GENERAL HOSPITAL BEDS. There is to be no more than four hospital beds per 1000 persons in a health systems area. Exceptions to this include urban areas that may have more beds to compensate for adjoining rural areas, and rural areas where a majority of the population served is more than 45 minutes away from the hospital. An 80 percent occupancy rate also will be required.

—OBSTETRICAL SERVICE. There should be at least 2000 deliveries annually in an obstetrical unit located in a Standard Metropolitan Service Area (SMSA) with a population of 100,000 or more (500 deliveries for an SMSA population under 100,000). A 75 percent occupancy rate is required of each obstetrical unit.

—PEDIATRICS. There should be a minimum of 20 beds in a pediatric unit. Where 10 percent of the population served is greater than 30 minutes away from the pediatric unit, the unit may have fewer than 20 beds. The proposed guidelines also cover the following types of health services and facilities: Neonatal Intensive Care Units, Open Heart Surgery Units, Cardiac Catheterization Units, Radiation Therapy, Computed Tomographic Scanners, and End-stage Renal Disease. Physicians who are interested in obtaining a copy of the proposed national guidelines for health planning should contact the SMS Communications Department in Madison: 608/257-6781. The deadline for comment is November 22. Physicians may submit their comments and recommendations to HEW at the Office of Planning, Evaluation and Legislation, Health Resources Administration, Center Building, Room 10-22, 3700 East-West Highway, Hyattsville, Md 20782.

CHILD ABUSE PREVENTION WEEK—NOVEMBER 14-20

Acting Governor Martin Schreiber proclaimed November 14 through November 20 as "Child Abuse Prevention Week." In 1976 more than 2000 children were reported as abused in Wisconsin and it is estimated that for every reported and treated case of child abuse, there are from 10 to 100 cases not reported and not treated. Among those required by law to report suspected child abuse (physicians, surgeons, nurses, dentists, hospital administrators, social workers, and school administrators), school personnel and social workers were the most frequent reporters. *Physicians reported less than 6 percent of the cases of alleged child abuse.* Because much child abuse goes unreported, is is important that physicians and other professionals be alert for clues in children of any age.

BOOK ON HEALTH-CARE DELIVERY NOW AVAILABLE

Crossroads to health care, a book explaining the alternatives open to small towns and rural areas in obtaining health-care delivery now is available on request to all Society physicians. The book was funded by the SMS Charitable, Educational and Scientific Foundation. Physicians interested in receiving a copy should contact the SMS Communications Department or Bill Wendle, CME coordinator, at SMS offices, Box 1109, Madison, WI 53701.

HOW BIG IS THE US HEALTH CARE SYSTEM?

The United States Health Care System is made up of about 380,000 doctors, 961,000 nurses, 7,000 hospitals, 3 million hospital beds, and 4.4 million health-care related workers. Last year, the nation spent $118 billion for health care, over eight percent of the Gross National Product, an average of $547 for each American. ■

SMS Council endorses AMA NHI plan

At its meeting on October 15 at the SMS Madison headquarters, the Council accepted a recommendation by the Commission on Governmental Affairs and its Committee on Federal Legislation to endorse the AMA's Comprehensive Health Care Insurance Act (HR 1818); one of several such bills currently being considered by Congress.

At the request of the AMA House of Delegates, each State Medical Society has been asked to submit its recommendations on the issue to the AMA Board of Trustees. The SMS Council endorsed the following statement:

"Both the Commission and the Committee share the view that the AMA's proposal is a forward method of assuring the availability of health insurance to all people. We do not believe that the AMA proposal 'nationalizes' the private practice of medicine. In fact, Section 41 of the Act specifically prohibits any federal interference in the private practice of medicine.

"The AMA proposal would provide comprehensive health insurance benefits through the private market to all persons, regardless of income. Employers would be required to offer full benefit coverage to employes paying at least 65 percent of the premium. Government subsidies would assist employers with increased costs and the government would pay the entire premium for the poor. No special taxes would be needed to finance the program.

"It is the view of both the Commission and Committee that the AMA's Comprehensive Health Care Insurance proposal is a workable alternative to other national health insurance plans currently before the Congress many of which would be fully financed by tax revenue and would extend government interference in practically every area of medicine."

The Council also recommended to the AMA that it address the issue of cost containment of total health-care expenditures in HR 1818. The Council suggested that the areas in which cost containment might be effected are: health education; coinsurance and/or deductibles in any comprehensive national health insurance program; making HSAs more effective; and more effective use of physicians' committees in hospitals for the review of equipment purchases. ■

Other Council action on October 15, 1977

Meeting in Madison on October 15 at the State Medical Society headquarters in Madison, the Council:

- Recommended to the House of Delegates an amendment to the SMS Bylaws extending voting membership on the Society's commissions and committees to Auxiliary representatives.
- Deferred further discussion of the present corporate "owner" relationship of the SMS to WPSIC (Wisconsin Physicians Service Insurance Corp) until its December 10 meeting. The Council also proposed a meeting between the SMS Council and the WPSIC Board of Directors for early 1978.
- Asked the SMS Committee on Health Screening and Immunization to consult with the Section on Pediatrics to develop a more consistent policy between physicians and the State Department of Health and Social Services (DHSS) in regard to standards for public immunization programs and the handling of the related liability questions. The Council also requested that the Committee, with the Section on Pediatrics and the Section on Internal Medicine, develop a protocol for adult immunizations.
- Approved creation of an ad hoc joint committee with representation from Wisconsin Health Care Review, Inc (WHCRI) and the DHSS to study the question of "unnecessary surgery" in cooperation with the Wisconsin Regional Medical Program, Inc (WRMP).
- Recommended to the 1978 House of Delegates that it implement for 1979 the following 1975 House action: "that future years' dues are to be adjusted annually to recognize the inflationary effect on the Society's budget," so that annual dues are structured to reflect, but not to exceed, the annual Consumer Price Index (CPI) rate.
- Authorized the Commission on Governmental Affairs to create a special committee to work with legislators who are seeking to develop a statutory definition of brain death. Jules D Levin, MD, Milwaukee, president-elect, is to chair the group.
- Urged physicians to contact the Governor and urge a veto of the chiropractic bill, SB 108.
- Urged physicians to contact their state representatives urging the support of the following bills on professional liability: AB 705, which establishes a statute of limitations for minors involved in liability claims to age eight or three years, whichever is later; AB 716, which establishes a voluntary binding arbitration agreement system between physicians and their patients as an alternative to the existing liability procedure; and AB 717—"nonduplication of benefits statute," which provides that benefits already received by a successful plaintiff in a professional liability action via Social Security, Worker's Compensation, and private health insurance benefits will be deducted from the award granted by a panel, court or arbitration panel.
- Accepted a proposal by the Commission on Mediation and Professional Ethics that the Commission continue to monitor the practice of a physician whose practice patterns involved outdated medical procedures and who had agreed to end such practices.
- Supported in principle the concept of the private sector conducting quality assurance peer review on a statewide basis, and requested that the details of the program by which WHCRI is to accomplish this be developed by WHCRI and be returned to the Council for review. ■

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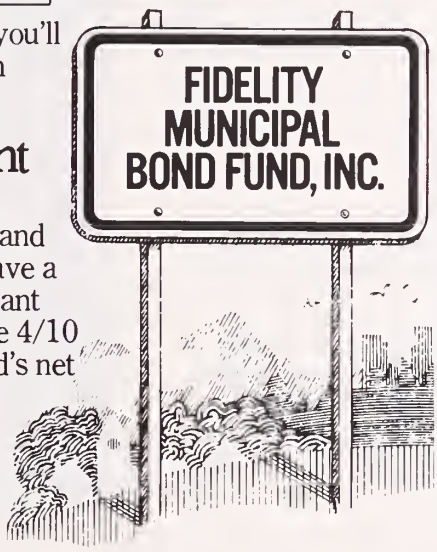

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Medical Defense Cmte, State Bar group meet

At its regularly scheduled meeting October 21 at SMS offices in Madison, the Medical Defense Committee:

(1) Met with representatives of the State Bar's Grievance Committee. Discussion centered on ways the Physicians Alliance committee and the State Bar group could work together to alleviate serious communication problems between physicians and their insurance company-appointed lawyers assigned to handle the defense of alleged malpractice.

(2) Discussed a case in which a physician was sued for $175,000 by a youth who alleged an adverse reaction as a result of an injection given during a mass immunization. The physician's insurance company urged settlement of the case for $2,500 without admission of liability. The case is directly related to physician support of public immunization clinics where physicians are required to accept liability for clinic procedures, personnel, equipment and supplies over which they have no control. Efforts to relieve this liability are underway with the State Division of Health. ■

Attention! Physicians over 70 years old

The Society reminds physicians who are over 70 years of age that they are *not* required to pay AMA dues as long as they are regular members of their state medical society.

Upon request, this may become effective the year after the physician reaches the age of 70 and cannot be made retroactive.

The physician must make request to his county or state medical society and he must continue his membership in the state society to be eligible.

The dues-exempt classification does not include receiving AMA publications, but they can be obtained by direct subscription through the AMA.

Other AMA dues exempt classifications may be requested through the county or state medical society for the following reasons: financial hardship, illness, retired from active practice, temporary service in the Armed Forces, as well as the over-70-years-of-age category.

While the State Medical Society of Wisconsin has an associate membership classification (less than 240 hours of practice per year) which exempts a retired physician member from payment of dues regardless of age, it does require payment of state dues for those over 70 years of age who are in active practice.

The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classifications can be arranged. ■

Environmental Health Committee Appointed

The SMS Commission on Governmental Affairs has formally appointed members to its new Committee on Environmental Health. Commission Chairman Joseph M Lubitz, MD, Oconomowoc, has named Wendelin W Schaefer, MD, of Sheboygan to chair the new committee. The Environmental Health Committee was created by the Commission in response to inquiries from various legislators for SMS input into environmental legislation from a health perspective (see September WMJ). The first meeting of the Committee probably will occur early in December. ■

HSA slide show available for county society meetings

The State Medical Society has produced a 12-minute slide program, complete with music and narration, explaining the need for more physician involvement in the Health Systems Agency (HSA) process.

The program explains HSA structures and programs, and should provide an incentive for members at the county society level to become involved. If you wish to schedule the slide show, call the Physicians Alliance Division at the SMS in Madison, 608/257-6781. ■

Special notice to participants in SMS-sponsored member retirement (Keogh) plan

When the SMS Plan (GA 1521) was restated to comply with ERISA requirements (GREEN SHEET No 3-A, March 1977), participants were promised explanatory information at a later date.

It now appears that direct mailings have been made by the funding agency rather than through administrative channels.

If participants have any questions, they should contact Mr Robert Heaps, Seefurth-McGiveran Corp, 757 North Broadway, Milwaukee, Wis 53202; telephone 414/271-6420. ■

JUNE 1977 BLUE BOOK UPDATE

In the SMS Officers and Councilors 1977-1978 listing, page 75, the term of the Speaker Albert J Motzel Jr, MD should be 1977-1979. The speaker's term runs two years, rather than one.

On page 79, the Committee on Nervous and Mental Diseases now has been changed to Committee on Mental Health.

In the listing of members of the Committee on Federal Legislation of the Commission on Governmental Affairs, page 79, John U Peters, MD of Fond du Lac has been appointed to represent the Academy of Family Physicians and Robert Lotz, MD of Eau Claire represents the Third Congressional District; Donald Chisholm, MD, Milwaukee, was appointed to represent the Section on Ophthalmology.

In the Officers of Specialty Sections of the State Medical Society listing, pages 84-85, the following changes have been made:

OPHTHALMOLOGY

Co-chairman: Arthur W Tacke, MD, 777 W Glencoe Pl, Milwaukee 53217; Donald E Chisholm, MD, 10425 W North Ave, Milwaukee 53226

Secretary-Treas: Richard K Dortzbach, MD, 1025 Regent St, Madison 53715

Delegate: Edwin L Downing, MD, 719 Doctors Ct, Oshkosh 54901

Alternate: Dennis J Kontra, MD, 5814 Washington Ave, Racine 53406.

PLASTIC SURGERY

Chairman: Donald M Levy, MD, 425 E Wisconsin Ave, Milwaukee 53202

Secretary-Treas: Jerome J Luy, MD, 425 E Wisconsin Ave, Milwaukee 53202

Delegate: Harold J Hoops Jr, MD, 704 South Webster Ave, Green Bay 54301

Alternate: George J Korkos, MD, 2300 N Mayfair Rd, Milwaukee 53226.

In the listing of County Medical Society presidents and secretaries, pages 81-83, the following changes have occurred:

MONROE: Gustave A Landmann, PO Box 552, Tomah 54660, is now the president; and Jack D Brown, 202 South K St, Sparta 54656, is the new secretary.

WINNEBAGO: James L Basiliere, 515 Doctors Court, Oshkosh 54901, is the new president.

On page 85, the Chairman of the Section on Surgery is P Richard Sholl, MD (not P Richard Shell). ■

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MEMBERSHIP REPORT

This listing appears as o newsworthy feoture ond is not intended to reflect the totol membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of September 9, 1977

NEW MEMBERS

Key: (Dote of birth, membership classificotion; specialty/sub-specioity)

County Medical Society

CHIPPEWA

Kennedy, Richard D, 2125 Heights Dr, Eau Claire 54701 (1939, Regular, Orthopedic Surgery, Certified)

DANE

Beasley, John W, 777 S Mills St, Madison 53715 (1942, Regular, Family Practice, Certified)
Christensen, Dennis, 1020 Regent St, Madison 53715 (1942, Regular, Obstetrics and Gynecology, Certified)
Evans, Bruce W, 2825 Century Harbor Rd, Apt 4, Middleton 53562 (1949, Resident, Anesthesiology)
Heaney, Eric S, 205 Lakewood Blvd, Madison 53704 (1948, Resident, Family Practice)
Licklider, Gary M, 1313 Fish Hatchery Rd, Madison 53715 (1945, Regular, Urology)
Miley, Charles E, III, 601 Copeland St, Madison 53711 (1945, Regular, Neurology)
Perelman, Robert H, 202 S Park St, Madison 53715 (1946, Regular, Pediatrics, Certified)
Ridgeway, Hal B, 3006 Northbrook Dr, Middleton 53562 (1950, Resident, Dermatology)
Siegel, Charles J, 2630 Amherst Rd, Middleton 53562 (1949, Regular, Pediatrics)
Starling, James R, 9 Carillion Dr, Madison 53705 (1943, Regular, General Surgery, Certified)
Tu, Her-Lang, 26B University Houses, Madison 53705 (1939, Resident, Internal Medicine/Neurology)
Whitehouse, Robert J, 3602 Atwood Ave, Madison 53714 (1948, Regular, Family Practice)

JEFFERSON

Campbell, Craig W, 200 S Lewis St, Columbus 53925 (1934, Regular General Surgery, Certified)

MILWAUKEE

Knavel, James L, 8700 W Wisconsin Ave, Milwaukee 53226 (1943, Resident, Orthopedic Surgery)

PORTAGE

Gehin, Francis E, 2009 W River Dr, Stevens Point 54481 (1919, Regular, Internal Medicine, Certified)

WAUKESHA

Blatnik, Steven, W180N7950 Town Hall Rd, Menomonee Falls 53051 (1945, Regular, Orthopedic Surgery)
Cummings, Patrick Jr, 17050 W North Ave, Brookfield 53005 (1944, Regular, Orthopedic Surgery)
Gardner, James D, 434 Madison St, Waukesha 53186 (1949, Resident, Family Practice)
Laabs, John E, 434 Madison St, Waukesha 53186 (1949, Resident, Family Practice)
Nagel, James H, 1111 Delafield St, Waukesha 53186 (1944, Regular, Ophthalmology)
Williams, Thomas H, 434 Madison St, Waukesha 53186 (1949, Resident, Family Practice)

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County Medicol Society

ASHLAND-BAYFIELD-IRON

Phillips, Martin D, Mellen, to 239 Primara, San Antonio, TX 78212

DANE

Carter, William L, Madison, to 4740 Girard Ave, South, Minneapolis, MN 55409
Meschievitz, Carlton, Madison, to 1224 MacArthur Ave, Ashland 54808
Pauly, Thomas J, Madison, to 811 5th Ave, SE, Cedar Rapids, IA 52403
Pederson, John F, Madison, to Rte 3, Box 299, Minocqua 54548

DOUGLAS

Lavine, Max M, Superior, to 5880 NE 14th Rd, Fort Lauderdale, FL 33334

KENOSHA

Najafzadeh, Moktar, Pompano Beach, FL, to 1204 Bahama Bend, Coconut Creek, FL 33066

MANITOWOC

Farkas, Mary E, Manitowoc, to USAF Hospital, Hafan 1070 NTO 400, APO Seattle 98742
Radl, Cyril, Manitowoc, to 7350 Via Paseo Del Sur, Apt 108, Scottsdale, AZ 85258

MARINETTE-FLORENCE

Rogers, Raymond J, Oconto, to 111 Shore Court, North Palm Beach, FL 33408

MILWAUKEE

Kozina, Thomas J, Milwaukee, to 8432 W Ryan Rd, Franklin 53132
Riddle, Patrick J, Waukesha, to 2135 NW 42nd Ave, Gainsville, FL 32605

OUTAGAMIE

Jasser, Mohamed K, Appleton, to PO Box 310, New Berlin 53151

PIERCE-ST CROIX

Docter, John C, Plum City, to Rte 1, Box 108, Arkansaw 54721

WAUKESHA

Taylor, Thomas F, Delafield, to 32569 West Esker Lane, Nashotah 53058

COUNTY-TO-COUNTY TRANSFER

Milwaukee to Waukesha: Stadler, James A, II, 9310 Ridge Ave, Wauwatosa 53226

DEATHS

Uecker, Ronald L, Marathon County, Nov 8, 1975
Denys, Glen F, Brown County, Aug 19, 1977
Lane, Francis C, Lincoln County, Aug 19, 1977 ■

OBITUARIES

◈County, State, AMA Members

James Henry Schultz, MD, 50, West Bend, died June 1, 1977 in West Bend. Born June 30, 1926 in Racine, Doctor Schultz graduated from Hahnemann Medical College in Philadelphia, Pa. Surviving are his widow; three daughters, Nancy Lynn, Lisa Carol, Cynthia Ann, and one son, Carl Arthur of Racine.

William L Harlan, MD, 52, formerly of The Monroe Clinic, died July 4, 1977 in Newburgh, Ind. Born June 2, 1924 in Michigan City, Ind, Doctor Harlan graduated from Indiana University School of Medicine in 1947. He was an associate professor of neurology and associate professor of preventative medicine at Creighton University, Omaha, Neb, prior to joining The Monroe Clinic in 1973.

◈ **Samuel L Henke, MD,** 73, Eau Claire, dermatologist at the Midelfort Clinic until his retirement in 1972, died Aug 1, 1977 in Eau Claire. Born Sept 13, 1903 in Weyawega, Doctor Henke graduated from the University of Wisconsin Medical School in 1929. Doctor Henke served in the United States Navy from 1943-1946. Surviving are his widow, Doris; one son, Timothy Henke, MD, Madison and a daughter, Mrs. Robert Fahres, Green Bay.

◈ **George Leonard McCormick, MD,** 80, Waukesha, died Aug 1, 1977 in Waukesha. Born Sept 7, 1896 in Waukesha, Doctor McCormick graduated from Marquette University School of Medicine in 1927. Doctor McCormick was a member of the Marshfield Clinic and served as its secretary for many years, In 1962 he moved to Waukesha and practiced there until his retirement in 1976. Surviving are his widow, Victoria; two sons, Michael McCormick, MD, Waukesha, and Phillip of Seattle, Wash.

George O Truex, MD, 62, Huntington, W Va, died Aug 1, 1977 in Lexington, Ky. Born May 13, 1915 in Remsen, NY, Doctor Truex graduated from the University of Louisville School of Medicine in Kentucky. He practiced medicine in Darien, Wis, from 1947-1966 and served as chief-of-staff of Lakeland Hospital, Elkhorn, in 1966. Surviving are his widow, Pauline; one daughter, Mrs Mary Michelle Fisher, Huntington, W Va; and one son, George T Truex of Kansas City, Kan.

◈ **Jake A Riegel, MD,** 88, St Croix Falls, died Aug 5, 1977 in St. Croix Falls. Born Mar 25, 1889 in Tracy, Minn, Doctor Riegel graduated from the University of Minnesota Medical School in 1917. He served in the United States Navy during World War I and also was founder of the St Croix Falls Medical Clinic. Surviving is a son, Fred B Riegel, MD of St Croix Falls.

Evelyn D Lipp, MD, 56, Madison, died Aug 7, 1977 in Madison. Born June 21, 1921 in Kursk, Russia, Doctor Lipp graduated from the University of Wisconsin Medical School, Madison. Surviving are two sons, Jonathan and David, Madison; and a daughter, Alana, Minneapolis, Minn.

Frank Whitton Govern, MD, 68, Milwaukee, died Aug 17, 1977 in Los Angeles, Calif. Born Dec 27, 1908 in Washington, DC, Doctor Govern graduated from Georgetown University Medical School. He served in the United States Army Medical Corps until retiring in 1968. Surviving are his widow, Liane; three sons, Kevin, Milwaukee; Frank and Mike, Los Angeles; and two daughters, Mrs. Trisha Fiucz, Bethlehem, Pa, and Mrs. Laura Wrightson of Tennessee.

Glen Francis Denys, MD, 71, Green Bay, died Aug 19, 1977 in Green Bay. Born Feb 18, 1906 in De Pere, Doctor Denys graduated from Marquette University School of Medicine in 1932. He retired from his practice in 1975. Surviving are his widow, Thelma; two daughters, Mrs W Daniel (Janet) Broderick, Green Bay and Mrs F Thomas (Jeanne) Ament, Milwaukee.

◈ **Francis Charles Lane, MD,** 72, retired Merrill physician, died Aug 19, 1977 in Merrill. Born Jan 2, 1905 in Merrill, Doctor Lane graduated from Marquette University School of Medicine in 1929. He served in the United States Army Medical Corps during World War II. Doctor Lane retired from his medical practice in 1969. Surviving are his widow, Rosemary; a daughter, Rosemary Russell, Scottsdale, Ariz; and a son, Peter, Redding, Calif. ■

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April 14-15

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Scientific Exhibits and Program

★

The Commission on Continuing Medical Education is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1978 Annual Meeting. The exhibits will be located in **Milwaukee.**

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space in the 1978 meeting are requested to file an application, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed. *Space assignments will be made as exhibits are approved by Commission on Continuing Medical Education.*

In-state exhibitors will have the following facilities provided by the State Medical Society: Fiberglass draping and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture, electrical connections, shelving or tables, and special lighting equipment (rented through Badger Exposition Service, Inc., Milwaukee, on form to be furnished all exhibits scheduled).

Booths for scientific exhibits will have fiberglass background, 8′ in height, and 3′ fiberglass side dividers. *No exhibit may exceed a height of 7′ from the floor.* Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level through Badger Exposition Service, Inc.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit.

Address your communications to:

MARTIN Z FRUCHTMAN, MD
Chairman of Scientific Exhibits
c/o State Medical Society of Wisconsin
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Madison, Wis. 53701

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Max Fox Preceptor Awards

. . . were granted to Phillips T Bland, MD* of Westby and Herbert M Snodgrass, MD* of Janesville by the University of Wisconsin-Madison Medical School at separate functions in September.

The Max Fox Award recognizes a physician's participation in working with medical students in Wisconsin's Preceptorship Program which began in 1926 as an experiment in medical education. The Program was so successful that it has continued to the present. It was the first medical training program of its kind in the country.

Dr Phillips T Bland's medical school classmate, University of Wisconsin-Madison assistant dean Dr Sigurd E Sivertson, congratulates Doctor Bland (right) on his Max Fox Preceptor Award.

Dr Herbert M Snodgrass (left) is congratulated by Dr Sigurd E Sivertson, University of Wisconsin-Madison assistant dean and a former student of Doctor Snodgrass in the Preceptorship Program, on his Max Fox Preceptor Award. Dr Rocco J Vitacca* (seated at right) is president of the Rock County Medical Society. (Staff photo by Ken Opin)

The Preceptorship Program gives senior medical students "grassroots experience" by taking them out of the classroom and putting them into a real hospital situation. Medical students leave the UW-Madison Campus and work three or four months with preceptors in various cities in the state.

The Award is an ebony captain's chair with an engraved gold seal of the University of Wisconsin.

Doctor Bland's award was presented during a Westby community testimonial honoring the family physician for his 25 years of "dedicated community service." Appropriately the award was presented by a UW classmate, Sigurd E Sivertson, MD,* assistant dean and director of the Preceptorship Program.

Doctor Bland's broad spectrum of community roles includes: nine years a school board member and chairman during a major building campaign; team physician to all Westby High School athletic teams and sometime punting coach; designer of ski slopes and architect of the 90, 50, and 30-meter ski jumps at Westby; consultant in ski slope design; physician for the US ski team; and perceptor for approximately 180 medical students.

Doctor Snodgrass' presentation was made at a gathering of members of the Rock County Medical Society, Sisters of Mercy and directors of Mercy Hospital, officials from General Motors, and many personal friends.

Doctor Snodgrass took charge of the Preceptorship Program in Janesville in 1967 from his uncle, T J Snodgrass, MD, who had started it many years before. He continued until 1975 when he became medical director at the General Motors Assembly Division. In that eight-year period more than 100 medical students worked with Doctor Snodgrass at Mercy Hospital.

Doctor Sivertson in his presentation of the award to Doctor Snodgrass noted that preceptors work without pay and called Doctor Snodgrass' contribution a "bargain for the state." Incidentally Doctor Sivertson served his preceptorship in Janesville.

PHYSICIAN BRIEFS

Jeffery Menn, MD

. . . recently joined the medical staff of the Hirsch Clinic in Viroqua. Doctor Menn graduated from the University of Wisconsin Medical School, Madison, and served his pediatric residency at Cincinnati Children's Hospital and at Milwaukee Children's Hospital.

James A Greer, MD
Sherwin M Rudman, MD

. . . have joined the medical staff of the Jackson Clinic, Madison. Doctor Greer is a graduate of the University of Illinois Medical School and completed residency training at the Mayo Clinic. He has joined the Department of Ear, Nose and Throat. Doctor Rudman, a graduate of the University of Illinois Medical School, is a member of the Department of Obstetrics and Gynecology. His residency was completed at the University of Illinois Medical School.

Edwin F McNichols, MD*

. . . director of the Medical Intensive Care Unit at Edgerton Hospital, recently opened his office in Edgerton in the practice of Internal Medicine. Doctor McNichols, a member of the American College of Cardiology, also directs the cardiac stress testing laboratory at Edgerton Hospital.

Parnell Donahue, MD*

. . . pediatrician at Parkview Medical Associates, Ltd, Hartford, recently was elected a member in the American College of Sports Medicine. He is currently team physician for the Hartford Orioles and has worked closely with the high school athletic department for the past six years.

John F Cassidy, MD

. . . recently joined Ferrin Holmes, MD, in the practice of pediatrics at the Door County Medical Center. Doctor Cassidy graduated from St Louis University School of Medicine and also completed his internship there. His residency in pediatrics was taken at Children's Hospital in San Francisco. He served in the United States Army in Nuremburg, Germany, for three years.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Sidney E Johnson, MD*

. . . has been named medical director of the Marshfield Clinic. Doctor Johnson succeeds Russell F Lewis, MD,* who has held the post since its inception in 1969. Doctor Johnson graduated from the University of Wisconsin Medical School, Madison, and served his internship at Buffalo New York General Hospital. His residency, in internal medicine, was taken at Veterans Hospital in Minneapolis. He has served continuously on the Clinic's executive committee since 1970 and from 1973-1976, he was chairman of the Marshfield Clinic/St Joseph's Hospital Department of Medicine. He has held the position as vice-president of the clinic and has been a member of the Professional Practices Committee since it was established. Doctor Johnson received the AMA's PRA for Continuing Medical Education this year.

Johnson

Matthew D Davis, MD*

. . . UW-Madison professor of ophthalmology, has been awarded funding for sight-saving eye research by the March of Dimes Foundation. Doctor Davis will use his $21,000 grant to study eye defects in human albinos. Many albino animals, including white mice and Siamese cats, have defective visual nerves resulting in misaligned or wandering eyes, as well as areas of blindness or restricted vision. Davis' study will show whether similar optic nerve problems exist in humans.

Anthony Herrmann, MD*

. . . director of the medical research center of S C Johnson & Son, Inc, Waxdale plant, recently accepted a position as director of employe health and safety affairs for Johnson & Johnson, New Brunswick, NJ. Doctor Herrmann was honored at a party and given a plaque for outstanding service to the citizens of Racine County. Active in community affairs, Doctor Herrmann also has been chairman of the Racine County's Family Practice Preceptorship Program and chairman of the Clinical Toxicology Committee at St Mary's Medical Center, Racine.

Thomas C Meyer, MD*

. . . Madison, chairman of the Department of Continuing Medical Education and director of Independent Study Program at the University of Wisconsin Medical School, Madison, has been appointed chairman, Research in Medical Education Program Planning Committee of the Group on Medical Education at the Center for Health Sciences. The Committee has the responsibility of reviewing and selecting the research in medical education papers for presentation at the annual meeting of the Association of American Medical Colleges.

Bruce Kotila, MD

. . . Rhinelander, specialist in internal medicine, recently joined the medical staff of Schiek Clinic SC. Doctor Kotila graduated from Northwestern University Medical School and completed his residency at the Medical College of Wisconsin Affiliated Hospitals, Milwaukee. In 1975 he was selected Resident of the Year.

John J Smalley, MD*
Claude A Blain, MD

. . . have joined the medical staff of Skemp-Grandview Clinic in LaCrosse. Doctor Smalley, specialist in general surgery, graduated from the University of Illinois Medical School in 1964. Doctor Blain, a graduate of the University of Ottawa Medical School, is a specialist in ear-nose-throat. Doctor Smalley is certified by the American Board of Surgery and Doctor Blain is certified by the American Board of Otorhinolaryngology.

Michael C Janowak, MD*

. . . ear, nose, and throat specialist, recently was admitted to the medical staff of Watertown Memorial Hospital. He is a 1972 graduate of Loyola University School of Medicine, Chicago, and served a rotating internship at St Joseph's Hospital, Milwaukee. A four-year residency was taken at the Medical College of Wisconsin. Doctor Janowak also has an office in Oconomowoc.

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For answers to your questions, call without obligation for appointment.

James V Lacey, MD

. . . Green Bay, recently became associated with the Beaumont Clinic, Ltd. A 1970 graduate from the University of Michigan Medical School, he served his internship at the University of Michigan Affiliated Hospitals. Doctor Lacey served his residency at the University of Michigan, Ann Arbor, and completed a fellowship in hematology from Simpson Memorial Institute at the University of Michigan.

Stephen L Brenneke, MD

. . . recently was admitted to the medical staff of Watertown Memorial Hospital. He is in medical practice with Calman Pruscha, MD,* Oconomowoc, who also practices in Watertown. Doctor Brenneke graduated from the University of Oregon Medical School and served his internship at Milwaukee County General Hospital. His residency in orthopedics was taken at the Medical College of Wisconsin Affiliated Hospitals.

William Arnold, MD

. . . has joined the Department of Emergency Services at St Mary's Hospital Medical Center in Green Bay. A graduate of Marquette University School of Medicine, Doctor Arnold served his internship at New York Poly Clinic Hospital and Medical School in New York City. He previously practiced in Clintonville for 25 years before coming to Green Bay.

Donald R Griffith, MD*

. . . internist with the Midelfort Clinic, Eau Claire, recently was installed as president of the American Group Practice Association at its 28th annual meeting held in Houston, Tex. Doctor Griffith has served as a member of its board of trustees since 1973, has been active on its insurance committee and its committee on constitution and bylaws. He was elected vice-president in 1975. ■

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF OCTOBER 1977

3	Dane County Medical Society HMP Committee
4	Dane County Medical Society Board of Trustees
5	T-19 Provider Groups
6	WisPRO Review and Evaluation Committee
12	SMS Commission on Governmental Affairs
12	SMS Committee on Federal Legislation
14	Ad Hoc Committee on Quality Care Activities
15	SMS Nominating Committee
15	SMS Finance Committee
15	SMS Council
15	SMS Committee on Economic Medicine
18	Dane County Medical Society Annual Meeting
20	Task Force on Health Screening and Immunization
21	Medical Defense Committee of SMS Physicians Alliance Commission
21	WHCRI Board of Directors and Executive Committee
26	SMS Committee on Cancer and Commission on Cancer of Liaison Fellows of American College of Surgeons
28	SMS Commission on Continuing Medical Education

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parenthesis.

Wood Veterans Administration

. . . Center in Milwaukee has been chosen as the site for the first of the VA's new veterans homes, or domiciliaries, according to an announcement by A L Modin, center director. The $6.4 million construction project got underway in October when ground-breaking ceremonies were held on the VA grounds. Modin said the new structure will partially replace an 111-year-old building at the VA Center, and may be a prototype for future VA domiciliaries. To be built around service and support facilities in four units of 50 beds each, the new "modular" buildings will be adaptable to nursing care as well as to a variety of personalized living settings, Modin said.

St Joseph's Hospital

. . . medical staff in Chippewa Falls recently elected officers for 1977-78. They are MDs Ricardo S Obcena,* president; Fe Q Gonzaga,* vice-president; and Ralph C Frank,* secretary.

Wisconsin Allergy Society

. . . recently met and elected the following officers: Raymond L. Hansen, MD,* Marshfield, president; Morton Soifer, MD,* Milwaukee, president-elect; William Busse, MD, Madison, secretary-treasurer. Bruce A Polender, MD,* LaCrosse was elected member-at-large to the executive committee. The terms of these officers are for two years. John Ouellette, MD,* Madison, is the delegate to the State Medical Society of Wisconsin.

The Wisconsin Council

. . . of Child and Adolescent Psychiatry recently held its organizational meeting in Madison. The Council is comprised of psychiatrists who work with children and adolescents throughout the state. Jack C Westman, MD,* of the University of Wisconsin, Madison, was elected president, and John T Anderson, MD, of the Medical College of Wisconsin, Milwaukee, was elected secretary-treasurer.

Watertown Memorial Hospital

. . . recently elected new officers for the year 1977-78. They include MDs Brigido Calado,* vice-chief-of-staff, and Douglas Wilson,* secretary-treasurer. Eugene Schuh, MD,* is chief-of-staff.

Oconto Memorial Hospital

. . . recently announced two new medical staff appointments. David Losh, MD, Davenport, Iowa, has completed a residency in Family Practice; and Philip Eckstrom, MD,* formerly of Marinette General Hospital, is the physician in charge of the hospital emergency room during weekends.

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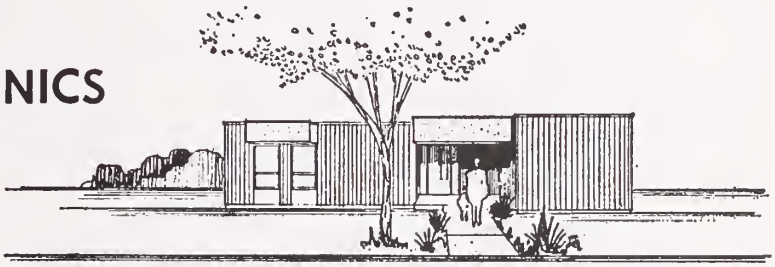

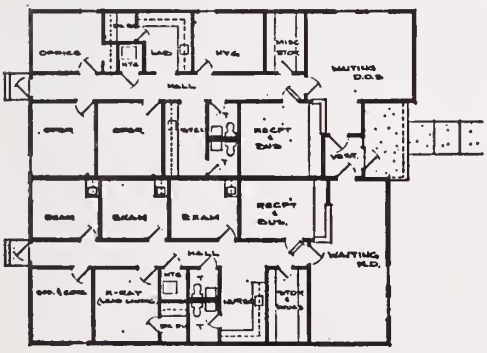

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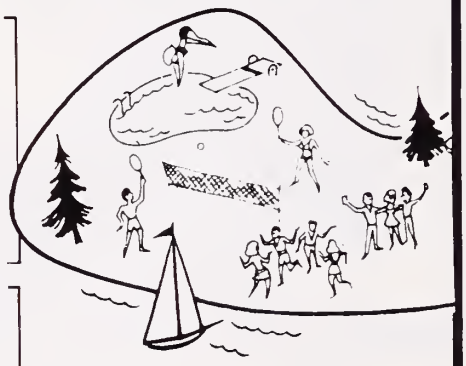

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Marquette-MCW Medical

. . . Alumni Association has elected Walter J Hogan, MD, Milwaukee, president-elect, succeeding Thomas C Puchner, MD,* Wauwatosa, when his term as president expires in May 1978. Doctor Hogan is a 1958 graduate of the Medical College of Wisconsin; Doctor Puchner graduated in 1946. H Mowat Waldren Jr, MD,* West Allis, was elected secretary-treasurer. There are 4,000 members in the Alumni Association.

UW System Board of Regents

. . . has been asked to appoint Bernard W Nelson, MD acting dean of the University of Wisconsin-Madison Medical School. The request for Doctor Nelson's appointment was submitted by UW-Madison Chancellor Irving Shain who also has named a search and screen committee to seek qualified candidates for dean of the Medical School. The appointment was made necessary following the resignation in September of Lawrence G Crowley, MD.* Dean of the school since 1973, Doctor Crowley is leaving the UW to accept the position of deputy dean at the Stanford University School of Medicine.

Doctor Nelson came to Wisconsin in 1974 when he was appointed associate dean for academic affairs of the Medical School. Before being named to that position, he served as associate dean for medical education and assistant professor of medical microbiology at the Stanford University Medical School. He received both his undergraduate and MD degrees from Stanford. A past chairman of the board of National Medical Fellowships, Doctor Nelson has been active both nationally and at the UW in promoting greater medical educational opportunities for minority students.

Members of the newly-formed search and screen committee include: Catherine DeAngelis, MD, pediatrics; Peter L Eichman, MD,* neurology (chairman); Perry A Henderson, MD,* gynecology and obstetrics; Harry J Karavolas, PhD, physiological chemistry; Dennis G Maki, MD, medicine; John R Marshall, MD, psychiatry; John R Pellett, MD,* surgery; Henry C Pitot, MD, oncology and pathology; Glenn S Pound, PhD, dean, College of Agricultural and Life Sciences; Margaret Ryan, medical student; Roberta Wallace, health systems engineering; and Richard C Wolf, physiology. ■

WPS

report

for Wisconsin Physicians

Volumn VI, Number 6 November 1977

PATIENT HANDBOOKS

Regardless of your specialty or practice, a carefully-planned patient handbook can be a valuable tool. It can save you time and energy, improve patient relations and promote patient health education.

If you are a specialist, for example, a handbook can inform your patients what your specialty entails. You can tell them if you limit your case load by special procedures or by anatomical areas, or if you see patients on a referral basis only. If you are a member of a partnership or group practice and share the patient load from time to time, you can explain to the patient how this benefits them.

A patient handbook can advise your patients of such matters as appointment scheduling, office hours and cancellations. You can tell your patients how far in advance to request an appointment or to make a cancellation. You can encourage your patients to describe their problems as fully as possible to your staff so that a proper appointment can be made. When discussing office calls, you can include your policies on house calls, evening, weekend and holiday service.

The telephone is one of the most common and useful ways of communicating with your patients. In a handbook, you can tell your patients if you charge for telephone consultations, or if your staff will call them with test or lab results. You may wish to inform your patients to call you before they call a hospital on an emergency problem, as well as to indicate appropriate procedures for after-hours emergencies.

If you use an answering service, a brief discussion of how it works will avoid repeated call-backs. If your practice typically occasions delays in your appointment schedule, you may wish to explain that your assistants will call and advise patients of your changed schedule.

Many patients may find discussing money matters with you or your staff difficult and embarrassing. By stating your policies on fees and preferred payment arrangements, you not only inform your patient but make it easier to discuss these matters at the appropriate time.

Third-party reimbursement is so common these days that you may wish to include information on your insurance filing policies. You can offer the services of your business staff to help patients fill out insurance forms. You may also wish to stress the confidentiality of your patients' medical records in such matters.

Additional information you may want in your patient handbook, either to supplement office procedures or as an independent text, could include advice on common illnesses, injuries and infections. This information could save you time by providing your patients a convenient reference for effective self-care methods and guidance on when to contact you.

A patient handbook can be an important contribution to consumer education. The better educated the patient, the more wisely he will use available medical services. Increased awareness of potential health problems can improve early detection and treatment, avoiding more costly procedures at later stages of illness. Your booklet can include sections on preventive health care and health lifestyles.

If you are interested in developing a patient handbook, you can refer to a brochure entitled "Preparing a Patient Information Booklet," OP-441, available from the American Medical Association.

If you would like editorial assistance in preparing a patient handbook, from developing text to arranging the material in an easily referenced format, WPS Communications staff may be able to help you. When you have developed a proposed outline or drafted a text, contact Ray Rafalik at (608) 221-4711, extension 490, to arrange a meeting with our staff to discuss production costs, service charges or any other matters we may be able to help you with.

Please bring to your Medical Assistants' attention the portion of "Reports" relevant to their work.

If you have any questions or comments on "Reports," send them to WPS, Communications Division, 1717 West Broadway, Madison, WI 53713.

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To make sure that these claims are processed quickly by WPS, you must fill out the WPS claim form completely and accurately.

The claim form must be complete with the Reciprocity designations. If the three-digit number preceded by "N" does not appear on the physician's report form, the claim cannot be processed. Without the coding number, the claim form is incomplete and must be returned to you for completion. Please list all the charges for the patient, regardless of whether the services are included under WPS Reciprocity or not. WPS will determine its liability under the program. If there are any remaining charges which WPS cannot pay, the claim will be sent to the subscriber's "home" Blue Shield Plan. The "home" Plan will then process the remainder of the claim.

If you are interested in a complete listing of procedures and services covered by WPS under Reciprocity (which was too extensive to include with this article) write to Susan Burns of the WPS Professional Relations Department.

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WANTED: ORTHOPEDIC SURgeon and family physician to join incorporated clinic of nine physicians: eight family physicians, one general surgeon. Small community, northwestern Wisconsin, 100 miles from Minneapolis-St Paul. Borders farming area of Wisconsin and tourist area. Excellent outdoor recreation area. Indianhead Medical Group, Ltd, Rice Lake, Wis 54868. For information contact: Lloyd Cotts, MD, Tel: 715/234-9031. 11-12/77, 1-4/78

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MEDICAL OFFICE FURNITURE: Examining table, upright cabinet, equipment table, desk with chair and 6 wooden arm chairs—used in waiting room. Will contribute to anyone who will pay the cost of moving them. Contact Mrs John M Albino, 438 Shoreland Dr, Racine, Wis 53401. g8tfn/77

OFFICE AVAILABLE FOR LEASE for general physician or related specialty. 7400 West Brown Deer Road, Milwaukee—on North Ridge Lakes—new building nearing completion, will partition to suit. AC 414/445-3329 or AC 414/352-0809. 11tfn/77

RETIRED GENERAL SURGEON'S professional equipment for sale. Can be purchased in entirety or separately. Call 608/846-5661 between 8:30-10 PM. 8/77*

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77 ■

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Psychosomatic Aspects of Allergy. By Claude A Frazier, MD. Van Nostrand Reinhold, Division of Litton Educational Publishing, Inc, 450 West 33rd St, New York, NY 10001. 1977. Pp 257. Price: $14.95.

Toward a National Health Policy. Edited by Kenneth M Friedman and Stuart H Rakoff. Lexington Books, D C Heath and Co, 125 Spring St, Lexington, Mass 02173. Pp 257. Price: $18.00.

The Saccharin Ban: Risks vs Benefits. American Enterprise Institute for Public Policy Research, 1150 17th St, NW, Washington, DC 20036. 1977. Pp 42. Price: $2.00.

B T Behavior Therapy: Strategies for Solving Problems in Living. By Spencer A Rathus and Jeffrey S Nevid. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1977. Pp 314. Price: $8.95.

Health Sciences Librarianship: A Guide to Information Sources. Edited by Beatric K Basler and Thomas G Basler. Gale Research Company, Book Tower, Detroit, Mich 48226. 1977. Pp 186. Price: $18.00.

Together: A Casebook of Joint Practices in Primary Care. General editor, Berton Roueche. National Joint Practice Commission, 35 E Wacker Dr, Chicago, IL 60601. 1977. Pp 256.

Doctors as Managers of Health Teams. By Roman L Yanda, MD. AMACOM, 135 West 50th St, New York, NY 10020. 1977. Pp 271. Price: $15.95.

AMA Drug Evaluations. Third Edition. Publishing Sciences Group, Inc, 545 Great Rd, Littleton, Mass 01460. 1977. Pp 1326. Price $29.50.

Psychosocial Counseling in General Medical Practice. By Allen Hodges. Lexington Books, D C Heath and Company, Lexington, Mass 02173. 1977. Pp 116.

Managing Nonprofit Organizations. Edited by Diane Borst and Patrick J Montana. AMACOM, 135 West 50th St, New York, NY 10020. 1977. Pp 328. Price: $16.95.

Current Concepts in Radiology. Edited by E James Potchen. The C V Mosby Co, 3301 Washington Blvd, St Louis, MO 63103. 1977. Pp 453. Price $39.50.

Transvestites & Transsexuals: Mixed Views. By Deborah Heller Feinbloom. Dell Publishing Co, Inc, 1 Dag Hammarskjold Plaza, 245 East 47th St, New York, NY 10017. 1977. Pp 303. Price: $3.95.

Immunology of the Gut. Ciba Foundation Symposium 46. CIBA Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1977. Pp 376.

The Fetus and Birth. Ciba Foundation Symposium 47. CIBA Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1977. Pp 481.

Purine and Pyrimidine Metabolism. Ciba Foundation Symposium 48. CIBA Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1977. Pp 369.

Please Remember Me. By Mari Brady. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1977. Pp 104. Price: $5.95.

The Hite Report. By Shere Hite. Dell Publishing Co, Inc, 1 Dag Hammarskjold Plaza, New York, NY 10017. 1976. Pp 638. Price: $2.75

NASW Register of Clinical Social Workers. National Association of Social Workers, Inc, 1425 H St, NW, Suite 600, Washington, DC 20005. 1976. Pp 456 & Supplement pp 227. Price: $25.00.

Review of Medical Physiology. 8th Edition. By William F Ganong, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1977. Pp 599. Price: $12.50.

General Ophthalmology. 8th Edition. By Daniel Vaughan, MD and Taylor Asbury, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1977. Pp 379. Price: $12.00.

Review of Physiological Chemistry. 16th Edition. By Harold A Harper, PhD; Victor W Rodwell, PhD; and Peter A Mayes, PhD, DSc. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1977. Pp 681. Price: $13.00.

Surgery in the United States. A Summary Report of the Study on Surgical Services for the United States. Sponsored jointly by The American College of Surgeons and The American Surgical Association. 1975. Pp 207.

How to Survive Being Alive. By Dr Donald L Dudley and Elton Welke. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1977. Pp 179. Price: $6.95.

A Time to be Born. By David Bell, MD. Dell Publishing Co, Inc, 1 Dag Hammarskjold Plaza, 245 East 47th St, New York, NY 10017. 1977. Pp 189. Price: $1.95.

BOOK REVIEW

PSYCHOSOMATIC ASPECTS OF ALLERGY

By *Claude A. Frazier, MD, PA,* Nostrand Reinhold Company, 1977. 257 pages. Price: $14.95.

To introduce Doctor Frazier's theories regarding the psychosomatic aspects of allergy, early chapters serve to define emotional stress, depression and anxiety as well as the psychosomatic and physiologic responses to them. Allergy, including asthma and eczema, are presented primarily in psychosomatic terms. Other chapters discuss such topics as biological clocks and the effects of weather on emotions. Numerous anecdotes are utilized to emphasize his points. However, the difficulty is that "data" used to substantiate his notions are gathered from the author's own personal anecdotes, plus those received via requests in medical journals for case reports from other physicians and very few published references are given. The biased, unscientific nature of this approach is obvious.

In subsequent chapters, descriptions of various allergic diatheses are presented simply and provide a relatively easy-to-understand picture of asthma, allergic rhinitis, eczema, urticaria and contact dermatitis, all of which would be helpful in patient education. However, much of this description is overly-simplified and not in keeping with modern concepts of the basis of many of these diseases. For example, eczema is attributed to sensitization from a multitude of allergens when, in fact, allergens are rarely identified in the eczema patient and the condition is now thought to be more of a disorder of autonomic imbalance with certain immunological abnormalities. Urticaria and angioedema, both usually idiopathic conditions (with a few well-defined exceptions), are said to have major emotional aspects, a view which would be argued by many.

Further topics as allergy of the nervous system, the Tension-Fatigue Syndrome and even schizophrenia are described with unscientific data and case reports as their basis. Again, stories are presented which seem to fit his hypotheses, rather than drawing firm conclusions from scientifically-derived observations.

In a chapter on some of the more common aspects of allergy, specific helpful guidelines for management, including allergen avoidance and advice for school teachers, are given. However, the final chapter of the book is somewhat egotistical and superfluous, describing the author's clinical acumen, a feature which is common throughout most chapters and which is not only a bit overdone but more than a bit boring. Completely irrelevant to the book's theme is the appendix which contains such features as dust, and mold control measures, elimination diets and methods to stop smoking, among others. While important in the management of the allergic patient, they seem out of place in this text devoted to the psyche.

The author's style is exceedingly colloquial with frequent conversational dialogue. Unfortunately, presenting theories in the first person lends itself to a question of credibility, especially when the basis for these postulates are mostly anecdotes.

In summary, Doctor Frazier is an unusually prolific writer and has compiled a good deal of information into this book. Anyone reading the text should recognize his theories for what they are: compilations of anecdotes woven into various themes, but little of which have any current sound scientific basis. The field of allergy often has been plagued with a suspicious and unscientific reputation and its modern scientific breakthroughs don't need the presentation of some of the unproven tenants which Doctor Frazier presents us in this book. I doubt that the pediatrician, internist, or family practice physician will draw much in the way of instruction, patient understanding, or help in management from this book.—J BRENT KOOISTRA, MD ■

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

Medical College of Wisconsin

Winter Refresher Course for Family Physicians

Thurs-Fri-Sat/Jan 19-20-21, 1978
Pfister Hotel & Tower/Milwaukee

Two and one-half days. AMA Physician's Recognition Award, 16-18 credit hours. AAFP, 16-18 credit hours.

Course director: Thomas F Garland, MD, Associate Professor of Family Practice, and Program Director, Family Practice Residency Program, Deaconess Hospital.

Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians.

* * *

Further details: Dept of Family Practice, MCW, 610 North 19th St, Milwaukee, Wis 53233.

1977 WISCONSIN

Dec 12: Health Planning Council Annual Meeting, Sheraton Inn, Madison.

Dec 14: *In-Depth Teaching Program,* Madison General Hospital, Madison.

1978 WISCONSIN

Jan 19: *In-Depth Teaching Program,* St Marys Hospital Medical Center, Madison.

Jan 19-21: *Winter Refresher Course for Family Physicians.* Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians. Pfister Hotel and Tower, Milwaukee.

Jan 28-29: St Mary's Hospital International Burn Symposium, Milwaukee. See details elsewhere in this section.

Feb 1-4: *A Comprehensive Approach to Endoscopy,* Medical College of Wisconsin, Milwaukee. Details elsewhere in this issue.

Feb 3: *Cleaning, Disinfection and Maintenance of Endoscopes,* Medical College of Wisconsin, Milwaukee. Details elsewhere in this issue.

Feb 15: *In-Depth Teaching Program,* Methodist Hospital, Madison.

Mar 1-Apr 5: *Recent Advances in Internal Medicine for the Practicing Clinician; Series 6: Infectious Disease,* Medical College of Wisconsin, Milwaukee.

41st Annual
New Orleans Graduate Medical Assembly

March 31 - April 4, 1978

Meeting Theme:
The High Risk Patient

Accreditation:
AMA-Category I/AAFP, ACEP

Program Director:
Oliver H Dabazies Jr, MD FACS

Fee: $200 nonmember physicians. Military: $100. Students, residents, interns and fellows: complimentary registration.

Write or phone:
New Orleans Graduate Medical Assembly, Room 1538 Tulane Medical Center, 1430 Tulane Ave, New Orleans, La 70112; 504/525-9930. 11-12/77, 1-2/78

Mar 16: *In-Depth Teaching Program,* UW Center for Health Sciences, Madison.

Mar 29-Apr 5: *Gynecological Pathology, Cytogenetics, Endocrinology,* Medical College of Wisconsin, Milwaukee.

Mar 30-Apr 1: Second Annual *Ophthalmology Current Concepts Seminar '78* of the University of Wisconsin-Madison. Lectures and workshops. Sponsored by the Dept of Ophthalmology Faculty, University Hospitals, Madison; at The Wisconsin Center, Madison. Info: Mrs Margaret Kelm, UW Hospitals, 1300 University Ave, Madison, Wis 53706.

Apr 13-15: SMS Annual Meeting, MECCA, Milwaukee. Headquarters Hotel: Marc Plaza.

Apr 6-27: *Diabetes* lectures around the state.

Apr 28: *Pediatric Anesthesia,* LaCrosse.

May: Spring Meeting, Wisconsin Neurological Society.

May 12: *Perinatal Medicine,* LaCrosse.

May 19-20: *Emergency Problems in Pediatrics,* UW-Madison.

1977 OTHERS

Dec 5-8: *Controversies in Gastroenterology,* American College of Physicians, in Philadelphia, Pa. Approved by AMA Advisory Committee on CME; may be used to fulfill 34 hours of Category I requirements for AMA-PRA.

Dec 5-9: *Advances in Diagnosis and Treatment in Clinical Medicine,* American College of Physicians, in Los Angeles, Calif. Approved by AMA Advisory Committee on CME; may be used to fulfill 27 hours of Category I requirements for AMA-PRA.

1977-1978 Madison
In-Depth Teaching Programs

Preliminary Schedule

Dec 14, 1977—(Wednesday) Madison General Hospital—(changed from Dec 21, 1977)

Jan 19, 1978—(Thursday) St Marys Hospital Medical Center

Feb 15, 1978—(Wednesday) Methodist Hospital

Mar 16, 1978—(Thursday) University Hospitals—(changed from Nov 17, 1977)

METHODS OF BURN TREATMENT

Second International Burn Symposium of St Mary's Hospital, Milwaukee

January 28-29, 1978

Co-chairmen: Burton A Waisbren, MD, Director of the Burn Research and Clinical Paradigm Laboratory and Associate Director of the Burn Center; and George E Collentine, Jr, MD, Director of St Mary's Burn Center.

Proof of Efficacy of Methods of Burn Treatment—Alternate Pathways will be the subject of the two-day session in which the foremost international burn surgeons will be allowed to present a specific method of burn treatment to an expert panel of critiquers, who will analyze the results. The audience will also be allowed to critique the presentations.

Presenters:

—**William F Monafo, MD,** Dept of Surgery, St John's Mercy Medical Center, St Louis, Mo.

—**Burton A Waisbren, MD,** St Mary's Burn Center.

—**George B Hart, MD,** Long Beach Hyperbaric Center, Long Beach, Calif.

—**John F Burke, MD,** Shriners Burns Institute, Boston, Mass.

—**Bent Sorensen, MD,** Professor of Surgery, University of Copenhagen, Denmark.

—**J Wesley Alexander, MD,** Shriners Burns Institute, Cincinnati, Ohio.

—**Irving Feller, MD,** University of Michigan Burn Center, Ann Arbor.

The first St Mary's Symposium dealt with the issue of skin banking. The objective of this session is to help those engaged in the treatment of burns to decide whether there is enough evidence for them to justify the use of the new modalities being discussed. Furthermore, the intimate exposure with the foremost experts on experimental design in this country will allow them to more scientifically evaluate and present new methods of treatment that they may develop.

For additional information contact Peter Hanson or Mary Sparks, 414/289-7144 at St Mary's Hospital, Community Relations Department, Milwaukee, 2323 North Lake Drive, PO Box 503, Milwaukee, Wis 53201.

University of Wisconsin Medical School-Madison

Department of Ophthalmology Faculty

2nd Annual

OPHTHALMOLOGY CURRENT CONCEPTS SEMINAR "78"

March 30 - April 1, 1978
Wisconsin Center, 702 Langdon St, Madison

Participating Faculty

Richard Appen, MD
George Bresnick, MD
Frederick Brightbill, MD
Suresh Chandra, MD
Matthew Davis, MD
Guillermo de Venecia, MD
Richard Dortzbach, MD
Terry Ernest, MD
Thomas France, MD
Paul Kaufman, MD
Burton Kushner, MD
Frank Myers, MD
Harry Roth, MD
Thomas Stevens, MD
Rodney Sturm, MD
Ingolf Wallow, MD

Info: Mrs Margaret Kelm, University Hospitals, 1300 University Ave, Madison, WI 53706

CLEANING, DISINFECTION AND MAINTENANCE OF ENDOSCOPES

GI Assistants course sponsored by the Section of Gastroenterology The Medical College of Wisconsin

February 3, 1978, Milwaukee, Wis

This seminar will deal with the prevalence and prevention of infectious diseases in the endoscopy unit, cleaning and basic maintenance of endoscopes and endoscopic equipment.

Participating in the presentations and discussions will be a microbacteriologist, an epidemiologist, endoscopy nurses and representatives of instrument and pharmaceutical companies.

This course is being held in conjunction with the 6th Annual Endoscopy Conference for Physicians, sponsored by the Medical College of Wisconsin, February 1-4, 1978.

Registration fee: $75

Info: Ms Marcis Pfeifer, RN, Course Director, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406

1977 AMA

Dec 4-7: AMA "Interim" Meeting, Chicago, Palmer House.

Dec 10-13: AMA Winter Scientific Meeting. Miami Beach, Fla, Hotel Fountainbleau.

Dec 20-23: AMA National Leadership Conference.

Dec 28-30: Seventy-third Annual Congress on Medical Education, Chicago, Palmer House.

1978 AMA

June 17-22: American Medical Association Annual Meeting, St Louis.

Dec 2-6: AMA House of Delegates Interim Meeting, Chicago.

Dec 7-10: AMA Winter Scientific Meeting, Las Vegas.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

November 28-December 11

Angina Pectoris: Diagnosis and Management with Michael V Herman, MD, Professor of Medicine and Chief, Division of Cardiology in the Department of Medicine, Mount Sinai Hospital and School of Medicine, New York City.

December 12-December 25

The Initial Management of Multiple Trauma with Clement A Hiebert, MD, thoracic surgeon, Maine Medical Center, Portland, Ore.

Accidental Hypothermia: A Consideration and a Priority with Cameron C Bangs, MD, Internist, Willamette Falls Community Hospital, Oregon City, Ore; and Clinical Instructor of Medicine, University of Oregon Health Science Center, Portland, Ore.

Recent Advances in the Management of Peptic Ulcer Disease with Henry J Binder, MD, Associate Professor of Medicine, Yale University School of Medicine, New Haven, Conn.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic videocassettes and half-inch Betamax formats.

1978 OTHERS

Jan 12-14: Colorado Regional Meeting of American College of Physicians in Colorado Springs. Physicians attending are eligible for credit toward AMA-PRA in Category I.

Jan 28-29: Second International Glaucoma Congress, at Americana Hotel in Miami Beach, Fla. Being held in conjunction with Annual Scientific Assembly of American Society of Contemporary Ophthalmology, Jan 30-Feb 3. Info: Dr John Bellows, Director, 6 North Michigan Ave, Chicago, Ill 60602. g8-12/77

Jan 30-Feb 3: Annual Scientific Assembly of American Society of Contemporary Medicine and Surgery, at Americana Hotel in Miami Beach, Fla. Meets criteria for 40 hours of credit in Category I for AMA-PRA. Info: John G Bellows, MD, PhD, Director, 6 North Michigan Ave, Chicago, Ill 60602; (312) 236-4673. g8-12/77

Mar 29-31: *Diagnostic and Therapeutic Advances in Gastroenterology,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Oct 17-21: *Medical Knowledge Self-Assessment Program Course,* Hyatt Regency, New Orleans, La. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa 19104.

A COMPREHENSIVE APPROACH TO ENDOSCOPY

6th Annual Endoscopy Conference

Sponsored by Section of Gastroenterology, The Medical College of Wisconsin

February 1-4, 1978, Milwaukee

The Medical College of Wisconsin's annual mid-winter endoscopy conference has gained recognition for its innovative and critical presentation of the teaching and interpretation of endoscopic techniques. In keeping with this tradition, a 3-day seminar on *A Comprehensive Approach to Endoscopy* will emphasize the latest advances in diagnosis, therapy and instrumentation.

An outstanding guest-faculty will discuss and demonstrate endoscopic techniques through lectures, case presentation and model demonstrations.

Small group discussion sessions will offer interaction between the faculty and the participants.

Guest Faculty

H Worth Boyce, MD, Tampa, Fla
Thomas Ihre, MD, Stockholm, Sweden
James W Manier, MD, Marshfield
John F Morrissey, MD, Madison
Jack A Vennes, Minneapolis, Minn
Jerome D Waye, MD, New York
Christopher B Williams, BM, MRCP, London, England
The Medical College of Wisconsin Faculty.

20 AMA Category I credits applied for.

Info: Joseph E Geenen, MD, or Walter J Hogan, MD, G I Section, 8700 W Wisconsin Ave, Milwaukee, Wis 53226.
Tel: 414/257-6047

NATIONAL MEDICAL SPECIALTY SOCIETIES

1977 Meeting Dates/Sites

Dec 3-8: American Academy of Dermatology, Dallas, Tex, Annual.

1978 Meeting Dates/Sites

Apr 24-26: American Academy of Neurology, Los Angeles.

Apr 23-27: American Association of Neurological Surgeons, New Orleans.

Sep 25-28: Annual Scientific Assembly, American Academy of Family Physicians, San Francisco.

Oct 16-20: Clinical Congress, American College of Surgeons, San Francisco.

Mar 13-16: Spring Meeting, American College of Surgeons, Cincinnati.

University of Wisconsin-Madison Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

CME Calendar—1977-1978

Dec 21: *Maternal and Infant Care: Optional Assessment of Series,* Beaver Dam Community Hospital, Beaver Dam.

Jan. 10: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Feb. 8: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Feb 14: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Mar 14: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Apr 11: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Apr 11-12: *Patient Education,* The Concourse Hotel, Madison.

Apr 13-15: *Seminar-Workshop in Radiology,* The Wisconsin Center, Madison.

Apr 21-22: *Conference on Dermatology,* The Wisconsin Center, Madison.

Info: Coordinator, Dept of CME, 601 Walnut Street, Madison, Wis 53706; phone: 608/263-2850.

CONTRIBUTIONS—CES FOUNDATION
September 1977

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for September 1977.

Unrestricted

Polk County Medical Society Auxiliary; Chippewa County Medical Society Auxiliary—*Voluntary Contributions*

Restricted

Lon D Babbitt, MD—*Student Loan Fund*
Membership Dues—*Aesculapian Society*

Memorials

Dr-Mrs Robert T Schmidt—*Leonard Kanard; Harry Conlon; John L Ford; Mr John Hughes (Brown County Loan Fund)*
State Medical Society—*Earl F Weir, MD; George L McCormick, MD; Jake A Riegel, MD; Samuel L Henke, MD; Francis C Lane, MD*
Dr-Mrs EJ Nordby—*Peter B Golden, MD; Ovid O Meyer, MD*
The Robert G Zach, MD Family—*Erwin Spring; Janet Brinkmeier (Aesculapian Society)* ■

AMA SPEAKER PROGRAM OFFERED TO COUNTY SOCIETIES

The AMA Office of the General Counsel is offering a new speaker program to County Medical Societies. AMA attorneys will speak at county society meetings on six topics: "The Parameters of Physician Advertising," "Legal Aspects of Hospital-Staff Relationships," "The Business-Legal Affairs of Medical Organization," "Legal Aspects of Physician-Patient Relations," and "Current Anti-Trust Legislation." The speaker provided through the AMA program is sure to liven up your county society meetings. Reservations for the program may be made through the Membership Legal Affairs Department at the AMA, 535 North Dearborn Street, Chicago, Illinois. The only fee involved is the speaker's traveling expense.

RUBELLA IMMUNIZATION BROCHURE NOW AVAILABLE

A brochure advising parents to have their children immunized against rubella and the red measles is now available to all SMS physicians. The brochure is a joint project of the SMS Communications Department, the Waukesha County Medical Society Auxiliary, and the Wisconsin Physicians Service. Presently, 35 to 40 percent of the nation's children are not immunized against common childhood diseases such as rubella, measles, polio and diphtheria-tetanus-whooping cough. Colorful, concise and medically correct, the 4 by 2½ inch sized brochure easily fits into billing statements and other mailings. To order copies for their offices, interested physicians should contact the SMS Communications Department at SMS offices in Madison: 608/257-6781.

SCHEDULE THE HSA SLIDE SHOW!

A reminder to all county societies that the State Medical Society's 12-minute slide presentation on Health Systems Agencies (HSAs) is available for your next meeting.

The slide program, complete with music and narration, explains the need for more physician involvement in the HSA process. Be sure to call the Physicians Alliance Division at the SMS Madison office (608/257-6781) to make arrangements to schedule the slide show for your county society meeting. Provide your county society with a first-rate program.

AMA MEMBERSHIP

AMA dues-paying members totaled 172,830 last year, exceeding expectations in the first year of a major dues increase. Total membership in the Association including dues-exempt physicians and affiliate members, was 203,584 in 1976.

PHYSICIAN SURVEYS CIRCULATE

Many physicians will receive two different economic surveys in their mail soon. The United States Census Bureau reports that it will survey about 100.000 physicians in the United States. If you are contacted by the Bureau, you will be asked to provide such financial information as gross receipts, capital expenditures, and gross value of fixed assets. Only employer-physicians will be surveyed. Physicians with more than two employees will be sampled either through a mailed questionnaire, or by Bureau examination or their Internal Revenue Service or Social Security Administration files. In addition, the National Opinion Research Center (NORC) is surveying about 12,000 physicians in the US as part of national study of health-care funding. The study was commissioned by the Health Care Financing Administration of the Department of Health, Education, and Welfare to evaluate the costs of physicians' practices in the 18 medical specialties. Physicians who are randomly selected to participate in this survey will receive a letter from the NORC explaining the survey and the telephone interview process to follow. The files of both the Census Bureau Survey and the NORC survey are exempt from Freedom of Information Act requests. ■

JOINT FINANCE COMMITTEE ENDORSES OPTOMETRY BILL

On November 1, the Legislature's Joint Finance Committee endorsed AB 281 which would permit optometrists to use drugs for diagnostic purposes. The Committee recommended passsage of the bill (by a vote of 12-0) and sent it on to the Assembly Rules Committee to await scheduling for Assembly floor action during the spring 1978 floor period. The Assembly Health and Social Services Committee, which held a public hearing on the bill, reported the bill to the Finance Committee without a recommendation last July. SMS strongly opposes this legislation. Optometrists have "blinded" some legislators to the real effect of the bill by implying that use of "diagnostic" drugs is not dangerous and is not opposed by physicians.

UPDATE ON PATIENT COMPENSATION PANELS

A report by the director of the Patient Compensation Panels, as directed by the Legislative Malpractice Committee, indicates that by the end of September 58 cases had been filed for disposition by the panel process, legislated in 1975. Status of those cases is:

- 28 cases for Informal Panels (three panel members): 14 Milwaukee Region; 6 Madison Region; 6 Eau Claire Region; and 2 Green Bay Region.
- 30 cases for Formal Panels (five panel Members): 17 Milwaukee Region: 7 Madison Region; 3 Eau Claire Region; and 3 Green Bay Region.
- 25 additional cases are pending.
- 33 other cases have been resolved by settlement, panel decision, or dismissal of the claim. Eleven cases in favor of the claimant prior to hearing; 5 cases with panel findings in favor of the claimant; 4 cases in favor of the respondent, either by settlement or dismissal; and 13 cases in favor of the respondent by panel findings.

Approximately $24,000 have been awarded to claimants, $16,700 by settlement prior to final panel determination, and $7,300 as a result of panel findings. Some cases were resolved prior to panel decisions in amounts undisclosed to the director of the panels. Three cases have been instituted in trial courts subsequent to findings by the panels. The status of these trials "de novo" is unknown at this time. Assembly Bill 704 was signed by Acting Governor Schreiber recently. The bill was developed by the Legislature's Interim Malpractice Committee and was strongly supported by the SMS Physicians Alliance. AB 704 makes a number of technical changes in Chapter 37, Laws of 1975, including clarifying malpractice panel membership. A decision is pending in the Wisconsin Supreme Court on the constitutional challenge to portions of Chapter 37, including the Patient Compensation Panels.

LEGISLATURE APPROVES IMPLIED CONSENT BILL

The Legislature in special session last month overwhelmingly approved Acting Governor Martin Schreiber's drunk driving legislation. The State Medical Society strongly endorsed the Governor's bill and its provisions to toughen the state's drunk driving laws. James Weygandt, MD, Sheboygan Falls, and chairman of the SMS Committee on Safe Transportation, testified for SMS before a Joint Legislative Committee and urged the Legislature to approve the bill. The bill, as passed by the Legislature, increases drunken driving penalties and makes refusal to take a chemical test for intoxication (blood, breath, or urine test including a preliminary breath test) a separate offense. Refusal would mean automatic license revocation for at least six months. ■

the wisconsin medical journal

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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Martin Schreiber, we salute you!

GOVERNOR MARTIN SCHREIBER'S veto of Senate Bill 108 (the chiropractic coverage bill) demonstrates not only political courage but also sound fiscal responsibility. He vetoed the bill because of his concern over its broad scope and failure to make exceptions for such entities as health maintenance organizations (HMOs).

While we might wish that he also would have said that he could not support a bill which would have granted status to a cult which deserves no status, we must not overlook the extent to which Governer Schreiber went out on a political limb in the interest of good government. As taxpayers, as consumers, as physicians, we applaud him.

Now that the Governor has taken action, the bill will be considered again by the full Legislature in a veto session in mid-January. If the veto is to be sustained, some legislators will have to change their minds. Now is the time to work toward that end. If you wish to participate, contact the State Medical Society: 608/257-6781, extension 115. Act now.—WJB

Governor Vetoes SB 108

IT IS DIFFICULT for a monthly publication to publish editorials pertinent to current events. However, Acting Governor Martin J Schreiber must be commended for his courageous action in vetoing Senate Bill 108. This legislation, which had passed both houses of the Legislature, proposed to mandate the inclusion of chiropractic services in every health insurance policy sold in Wisconsin.

There was considerable controversy and pressure involved. On September 22 there were two editorials giving advice to the Governor. One of these was entitled "Cure It With A Veto, Marty" in the *Milwaukee Journal* and the other was "Chiropractic Bill Merits Veto" in the *Milwaukee Sentinel*. Conversely, the *Madison Capital Times* strongly urged the Governor to sign the bill. The Governor's office was also deluged with letters. An aide in the Governor's office stated that the total mail on the chiropractic bill strongly favored the Governor signing it. The same staff person said that physicians had been writing their own letters, generally lengthy and giving detailed arguments against the bill. The correspondence was dominated by a two-page, single-spaced, typewritten form letter that chiropractors apparently were handing out at their offices that urged Schreiber to sign SB 108. The form letters naturally outnumbered genuine correspondence. The Governor's office also has a category of "real people" who are identified as those without a professional interest in legislation who write their own letters. The "real people" mail was fairly heavy on the opposition side (*ie*, for vetoing the bill).

On November 22 the Governor did veto the bill and the following day The *Capital Times* reported that angry chiropractors blasted the veto and resolved to work to overturn his action when the Legislature returns late in January. The *Capital Times* article quoted the Wisconsin Chiropratic Association spokesman as saying their leaders were upset because Schreiber, who was usually a friend of organized labor which had given strong support to the bill, had vetoed it.

It now is essential that our Medical Society members contact their senators immediately and urge support for the Governor and to sustain his veto.—VSF

Making Grandma cost-effective

PRESSURES TO reduce health-care costs increase daily, most of them arising from outside the medical profession, but now even physicians can be heard tossing such foreign terms as cost-benefit analysis and cost-effectiveness around.

Time was when only one consideration mattered: the well-being of the patient. Now because of economic pressures there is hesitancy in recommending an operation or prescribing a treatment unless the investment in time and money can be expected to yield a profit for society.

No one questions the performance of a coronary bypass on a 48-year-old executive, because he can be expected to be productive for several years afterward and ought to pay back the investment. But Grandma is 76, and frail, and needs a pacemaker. Would she qualify for it in a society where every medical undertaking must be scrutinized by an economist in a government agency? All she produces is a batch of cookies about twice a week—not a very major contribution to the grand scheme.

Up to this point no one has gone quite so far as to deny indicated treatment based on purely economic considerations, but that eventuality isn't as far down the road as it might have seemed a few years ago. As more and more government money is spent on health care, more and more government regulations appear—not aimed at improving quality of care but rather at cost-containment. If hospitals can be forced to close non-profitable services in order to produce

Editorial Director—WAYNE J BOULANGER, MD, Milwaukee

Editorial Associates—PHILIP J DOUGHERTY, MD, Menomonee Falls; LESLIE G KINDSCHI, MD, Monroe; RAYMOND A McCORMICK, MD, Green Bay; T H McDONELL, MD, Waukesha; JOHN P MULLOOLY, MD, Milwaukee

fewer, but larger, more economical ones, wouldn't the next logical step be to restrict services to the younger, healthier patients? How long do you think it will be before just such a suggestion is made?

As physicians we have a responsibility to see to it that money is not wasted in medical care. We can do this by writing appropriate orders, by not practicing defensive medicine, and by using our hospitals prudently. But we can't let economics interfere with good judgment and human considerations. The patient's welfare must always come first. If Grandma is 76 and needs a pacemaker, she ought to have it. Let us go on record now that we will never allow any agency to make decisions that can be made only by physicians.. —WJB

PS to wrestling

THE DERMATOLOGIST member (GAC) of the Editorial Board adds this postscript to last month's editorial *(Wrestling and weight control):* It should also be emphasized that the mats be kept clean and floor shoes should not be on the mats. No one with skin lesions should be allowed to wrestle. Herpes is spread by this close contact.

Malpractice crisis aftermath

WISCONSIN'S 1975 malpractice statutes must be more effective than we had reason to believe. At least they are effective enough to have induced a Madison attorney to challenge their constitutionality. The Wisconsin Supreme Court heard his arguments on September 1 and has not yet rendered a decision. It is significant to note that the State Bar of Wisconsin and the Wisconsin Academy of Trial Lawyers joined the Madison attorney as friends of the court, contending that the panel system and limitations on awards are contrary to the public interest and are unconstitutional.

In the brief filed by the Medical Malpractice Committee of the State Bar the following statements are made: (1) The so-called "crisis" was a fiction and did not exist in fact. [This refers to the malpractice crisis in 1975.] (2) The panel system and limitations on awards are contrary to the public interest. (3) The panel system invades the judicial province. (4) Health care in Wisconsin can be maintained without infringement upon individual rights.

As it expanded upon its statement that health care in Wisconsin can be maintained without infringement upon individual rights the Bar stated, "Simply put, a segment of the insurance industry no longer is willing to supply liability insurance at reasonable rates. The Bar believes the answer to this problem is to be found in an integrated program of risk-sharing among the members of the profession in question."

How to postpone taxes legally and earn interest on Uncle Sam's money

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In its conclusion the Bar further stated, "Of major concern to the State Bar is the general philosophical approach contained in this legislation, which shifts the burden of acts of negligence from the tortfeasor onto the tort victim and violates traditional notions of fair play. This is especially repugnant when feasible means exist for the health-care profession to secure liability insurance at reasonable rates without the extreme hardship currently being worked upon individual malpractice tort victims by Chapter 655 Stats."

Apparently Wisconsin lawyers are beginning to feel the pinch—WJB

Major burns

IN THIS ISSUE on page S/149 is an article from the Burn Unit at University of Wisconsin Hospitals. This describes the favorable experience with laminar airflow in the management of major burns. In August 1977 there appeared an article in *JAMA* that emphasized the advisability of transferring severely burned civilian patients to a definitive burn-care facility within the first hours following injury. None of the patients died during transportation or as a result of the transportation and the results were much better if the patients were transported before the complications began.

The advances in the treatment of burns have been dramatic. One recalls the use of dyes that resulted in board-like eschars. This was followed by the use of tannic acid jelly and early in World War II where there were severe shipboard fires, scars on the hands and face from this method of treatment were horrendous. This was followed by the use of boric acid ointments and cases of boron poisoning were reported. Later, the sulfa ointments were used with the usual complications from the sulfa. Then came picric acid and Furacin gauze dressings. Finally silver sulfadiazine dressings were used extensively in Viet Nam. Very recently there has been reported a 50% improvement in the survival rate of patients with widespread third degree burns using a new antibacterial burn cream containing cerous nitrate and silver sulfadiazine. The cerium salt was added to the conventional silver sulfadiazine because of its antibacterial action and the fact that it is poorly absorbed from local tissue sites.

There has been an interesting program at the Los Angeles County-University of Southern California

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Medical Center that was described in the *New England Journal of Medicine*. Twenty-four severely burned patients ranging in age from 19 to 90, were admitted to the hospital burn center. It was found that no one whose burns and age matched the victims' ever had survived and the patients were then given a choice of treatment. The patients themselves determined whether they should be kept alive with last ditch methods or be allowed to die quietly. All but three decided they wanted only basic care and pain medication, and subsequently all twenty-four died. This appears to be a realistic option.

No note on burns would be complete without commendation and recognition of the Burn Units at St Mary's Hospital in Milwaukee. This was a pioneer in Wisconsin and the dedicated staff there has a good solid generation of experience in the treatment of major burns.—VSF

A gift to the CES Foundation

SINCE 1955 the State Medical Society's Charitable, Educational and Scientific Foundation has been promoting professional medical education and research, public health education, assisting physicians who become needy, lending money to medical students, and conducting many other philanthropic purposes.

A contribution to the Foundation can be used as a means to pay tirbute to the memory of a respected friend, colleague, or relative. Or it can be used to honor the living on the occasion of birthdays, anniversaries, or other happy occasions. So the next time you're wondering what to give, think of the CES Foundation; it's a tax-deductible transaction, too. ■

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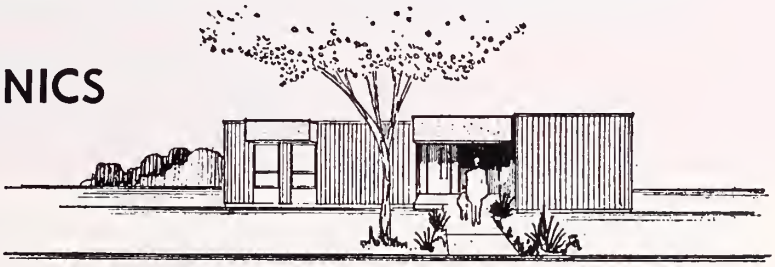

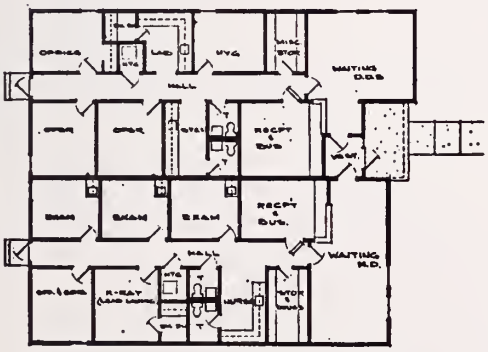

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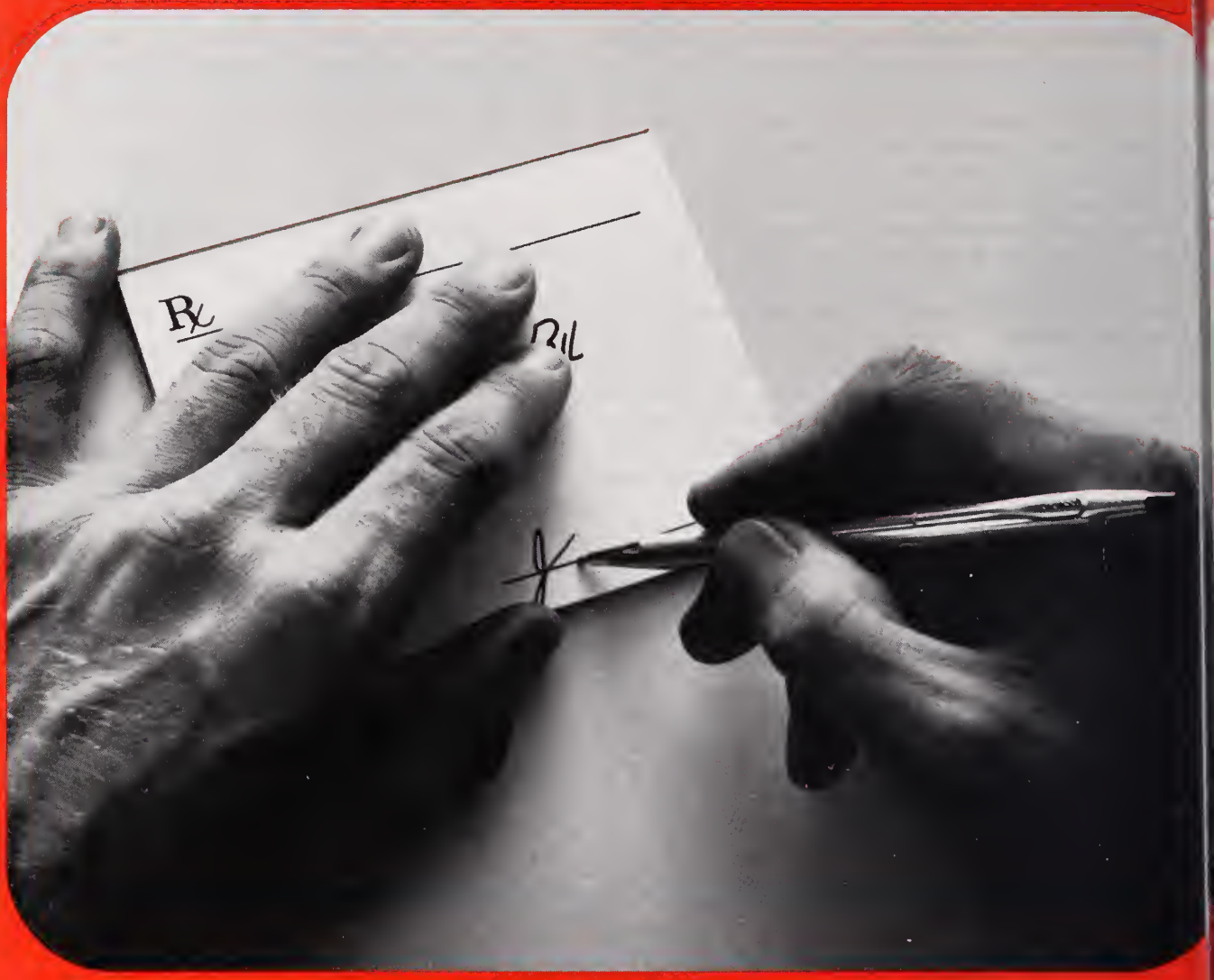

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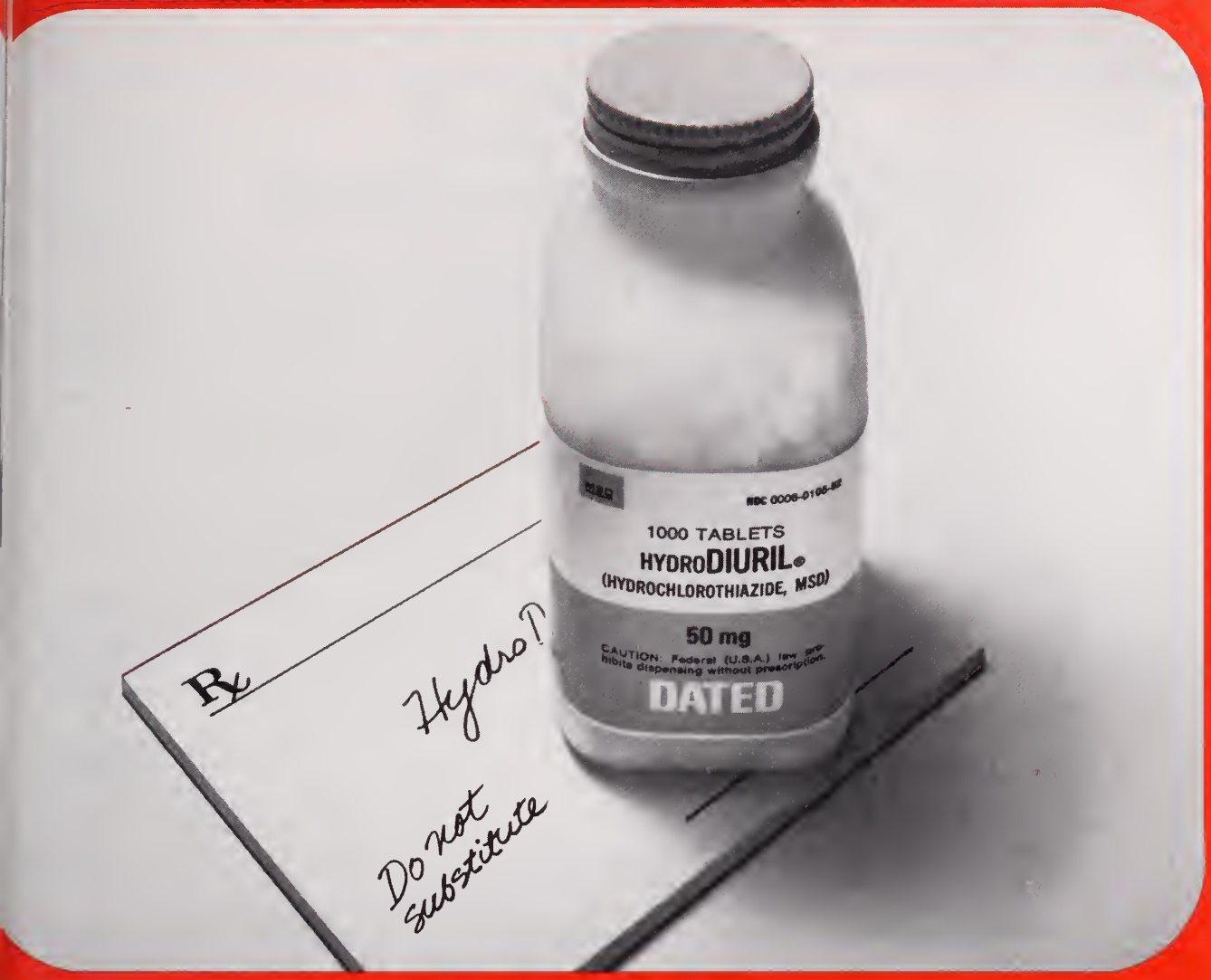
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increase ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

irment becomes evident, consider withholding or discontinuing uretic therapy. Thiazides may decrease serum PBI levels without gns of thyroid disturbance. Calcium excretion is decreased by azides. Pathologic changes in the parathyroid gland with hyperlcemia and hypophosphatemia have been observed in a few patients prolonged therapy; thiazides should be discontinued before testing parathyroid function.

dverse Reactions: *Gastrointestinal System*—Anorexia; gastric iration; nausea; vomiting; cramping; diarrhea; constipation; jaundice trahepatic cholestatic jaundice); pancreatitis; sialadenitis.

entral Nervous System—Dizziness; vertigo; paresthesias; headache; nthopsia.

ematologic—Leukopenia; agranulocytosis; thrombocytopenia; plastic anemia.

ardiovascular—Orthostatic hypotension (may be aggravated by cohol, barbiturates, or narcotics).

ypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing gitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress cluding pneumonitis; anaphylactic reactions.

ther—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; eakness; restlessness; transient blurred vision.

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ote: When used with other antihypertensive drugs, careful observaons for changes in blood pressure must be made, especially during itial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

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Intervertebral disc syndrome—from jogging?

To Doctors Guten and Harvey: I will admit as I am a confirmed jogger that my opinions are truly biased. In the early part of your article *(Herniated lumbar disc with leg paralysis associated with jogging—case report,* WISCONSIN MEDICAL JOURNAL, October 1977) you stated that the syndrome of low back pain in joggers has been rarely reported in the literature. You then stated that in your clinical experience that a middle-aged jogger could have significant low back problems. If you have seen many people with low back problems and herniated intervertebral discs, have you ever discussed and tried to decide what percentage who had herniated intervertebral discs were joggers? Your case report involves a man in his late 30s who has been running for ten years. It is obvious that this man did have an intervertebral disc syndrome, and had he not jogged there is no way for you to anticipate that he would not have developed the same syndrome.

In your review of the literature, it does not bear out your making a blanket statement that jogging causes herniated discs.

I can not believe that the *Wisconsin Medical Journal* could make the decision or recommendation on one case that investigation of the literature did not reinforce your conclusions.

JOHN M GUTHRIE, MD
November 7, 1977 Green Bay, Wisconsin

To the Editor: Your article in the October 1977 issue of the *Wisconsin Medical Journal* by Doctor Guten represents an appalling case of editorial irresponsibility. Doctor Guten's patient had been jogging for more than 10 years and developed an acute herniated lumbar disc. There is no evidence in the article to support the conclusion stated in the title that this was at all related to his jogging. Doctor Guten reviewed the literature again finding no correlation with jogging and acute discs and then, in a testimonial type of editorial summary concluded that running and jogging placed a chronic strain on the lumbar spine. Not only has your article and Doctor Guten mislead (sic) the physicians who read the journal but it has been a disservice to all health enthusiasts who use jogging as a means of staying fit. As you probably know, the article was picked up by the nonmedical press and headlines appeared in many of the state papers including *LaCrosse Tribune* sighting (sic) jogging as a cause of herniated disc.

The medical profession has frequently been categorized as being antiexercise and pro pills. Certainly Doctor Guten's article has done nothing to dispel that belief.

PARNELL DONAHUE, MD, FAAP
1004 East Summer Street
Hartford, Wis 53027
Nov 21, 1977 (414) 673-5745

First Appendectomy in Wisconsin

To the Editor: We have been asked to obtain the following information. Is there anyway to locate information as to where the first appendectomy was performed in the State of Wisconsin and by whom. Is it possible you could refer my inquiry to some department of the Wisconsin Society who might have this information?

LA CROSSE LUTHERAN HOSPITAL
AND COMMUNITY HEALTH CENTER
Mrs LaVerne Samb
Medical Librarian
1910 South Avenue
LaCrosse, Wis 54601
Nov 16, 1977 (608) 785-0530

EDITOR'S NOTE: Anyone having this information or suggestions as to where this information might be available, please contact Mrs Samb, or the *Wisconsin Medical Journal.* ■

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin.

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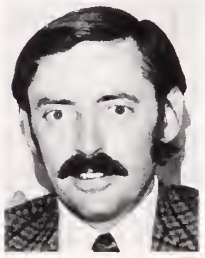
The influence of federal health policies in Wisconsin

WITH THE DEVELOPMENT of the Physicians Alliance, a new working relationship has been established between physicians and state government officials. Regular communication with legislators, the Governor, and the Department of Health and Social Services has resulted in greater consideration of medicine's viewpoint in the development of state health policy.

State health policies, however, are often a result of policies and directives of the federal government. Wisconsin's new certificate-of-need law, for example, was required by the National Health Planning and Resources Development Act (PL 93-641) passed by Congress in 1974. Approximately 3,000 bills are introduced in each session of Congress that relate in some way to health. About 300 of them have a direct impact on physicians and the manner in which we practice medicine here in Wisconsin.



PURTELL

Because of the volume of health-related measures considered by the Congress and the influence federal health policies have on Wisconsin government and Wisconsin physicians, the State Medical Society's Commission on Governmental Affairs established a Committee on Federal Legislation. The Committee is charged with reviewing federal health legislation, developing positions on key bills, and communicating those positions to Wisconsin's congressional delegation and to the appropriate congressional health committees. Membership on the Committee consists of a physician representative from each of Wisconsin's nine congressional districts, the Chairman of the Commission on Governmental Affairs, and the Legislative Chairman of the State Medical Society Auxiliary.

The Federal Legislation Committee meets monthly and has considered the following major health issues currently before the Congress:

• **Hospital Cost Containment.** President Carter's proposed Hospital Cost Containment Act would establish a 9% limit on inpatient revenue increases for all acute care hospitals and establish a $2.5 billion limit on capital expenditures. No certificate-of-need could be granted by a state that already has met its expenditure limit. Where hospital beds exceed 4 per 1,000 population or the occupancy rate is less than 80%, the Carter bill would prohibit the granting of a certificate-of-need that would increase bed capacity.

The Federal Legislation Committee voted to oppose the Carter proposal on the ground that it is an arbitrary and ineffective way in which to contain hospital costs. Congress appears to have shelved the Carter proposal, but it will consider cost-containment proposals by Senators Talmadge and Kennedy early next year. Meanwhile, the SMS Federal Legislation Committee is reviewing these alternative cost-containment bills.

• **National Health Insurance.** The Committee reviewed all of the major national health insurance proposals and opposed every one except the Comprehensive Health Care Insurance Act sponsored by the AMA. This proposal provides full health coverage through private insurance financed by employer-employee contributions. Unlike the Kennedy national health insurance proposal which is financed by tax revenue and run completely by the government, the AMA plan utilizes the private market, minimizes government involvement in medicine and permits the health-care system to operate without added controls and interference.

• **Medicare-Medicaid Fraud and Abuse.** The Committee endorsed in principle the Medicare-Medicaid Anti-Fraud bill which is the only health-related measure that has been signed into law by the President this year. The bill increases penalties for defrauding government health programs from misdemeanors to felonies with a maximum fine of $25,000 and up to five years imprisonment. It requires disclosure of certain business relationships between suppliers and providers of health services and authorizes PSROs to investigate and report fraud and abuse in government health programs.

• **Clinical Laboratories Certification.** The Clinical Laboratories Improvement Act would set standards for federal government certification of clinical laboratories to assure accurate and reliable laboratory testing. The Committee voted to support the principle of the bill, but in correspondence to congressional committees considering the bill, urged amendments that would exempt physician offices' labs serving not more than two physicians and eliminate the requirement for certification of technical personnel. These amendments would put the federal bill in step with Wisconsin's laboratory certification rules permitting the federal certification program to be administered in Wisconsin by state government.

• **Physician Extenders.** This bill would allow reimbursement to rural health clinics for services performed by physician assistants and nurse practitioners under federal health programs. It would allow reimbursement to the clinic (rather than the physician) whether or not a physician is present or the service is performed in the facility of a physician. The Committee felt strongly that reimbursement for physician extender services should be through

the supervising physician and not directly to the rural health clinic. Members of the Wisconsin congressional delegation were urged to support amendments to the bill that would retain such a reimbursement procedure.

• **Drug Safety.** The Drug Safety Amendments include a number of changes that provide consumers with more reliable information on drugs. The Committee supported portions of the bill that require proper labeling of drugs including the correct name and place of the manufacturer, packer, and distributor. After consultation with a representative of the Wisconsin Pharmaceutical Association, the Committee supported in principle the concept of patient package inserts that would provide the patient with information on the drug's purpose, side effects, and shelf life. The Committee strongly recommended that drug information on package inserts be prepared in simple terms, easily understood by the patient.

These are only a few of the bills that have been reviewed by the Committee on Federal Legislation. Others include President Carter's Child Health Assessment Program (CHAP), recombinant DNA research regulation, the National Labor Relations Act relating to the inclusion of housestaff, the HEW Appropriations Bill as it relates to the Hyde Amendment, and abortion, maternal and child health care insurance, reimbursement reform of Medicare and Medicaid programs, and many others.

Although most health measures are moving very slowly through this Congress, the Carter administration has placed priority on the enactment of cost containment legislation and national health insurance. Whether or not the administration succeeds may well depend on how effective physicians are in communicating intelligently with their representatives in the Congress. The Committee on Federal Legislation is attempting to open up lines of communication with our state congressional delegation. We want to establish a good working relationship so that when critical health bills are debated in Congress, our Congressmen and Senators have the concerns of Wisconsin physicians fresh in mind.

Any physician or Auxiliary member interested in national health issues and willing to participate in the work of the SMS Committee on Federal Legislation should write to me at the State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701. We welcome your interest and help.

—ROBERT F PURTELL JR, MD
Chairman, SMS Committee
on Federal Legislation
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Indications for mammography

RADIOLOGISTS AT THE University of Wisconsin believe that there are certain categories of patients in which an initial radiographic examination of the breasts is warranted. These include:

(1) **Patients in which a biopsy is indicated, regardless of age, or patients who had previous benign biopsies without preoperative mammograms.** Mammographic differentiation of a lesion approaches 90% accuracy. These mammographic examinations should be performed before needle or open biopsy. Both breasts should be examined, because 1.7% to 3% of patients have simultaneous, bilateral carcinoma. In addition, examination of the normal breast provides a standard for future examination in high-risk patients.

(2) **High risk patients,** determined either by clinical or mammographic findings, **include women with previous breast cancer, close family history of breast carcinoma, nulliparous patients, or patients with breast symptoms.** Also, **patients with diagnosed cancer of the colon, ovary, or endometrium** should be closely monitored, as well as **women on longstanding estrogen medication.**

(3) **Patients with a palpable mass or masses,** whether biopsy is contemplated or not.

(4) **Patients with large, difficult-to-examine breasts.**

(5) **Cancerophobic patients.**

(6) **Patients with metastases from an unidentified primary lesion.**

(7) **Asymptomatic patients over 40 years of age in order to radiographically evaluate risk.**

There is also justification for repeated radiographic examinations in certain types of patients. Statistical evidence indicates that some patients have a higher probability of breast-related problems, so these patients should routinely have specific single lateral projections made, even if they are asymptomatic. These are necessary in order to differentiate minute changes in the breast pattern. The appropriate interval, modality (film or negative xerography), and single projection should be considered on an individual basis. Included in the groups that need repeat films are:

(1) **Patients with prior breast cancer.** Examination of the opposite breast is recommended every six months after the initial operation for five years. Up to 16% of patients with breast cancer will eventually have a second primary lesion in the opposite breast; half of these lesions occur within the first six years after mastectomy.

(2) **Patients over 50 years old.**

(3) **Patients included in the high-risk group by radiographic examination.**

(4) **Patients with previous equivocal mammograms.**

(5) **Patients with dysplastic breasts in which there are histological findings that are considered premalignant in nature.**

(6) **Patients who have had plastic surgery of the breasts.**

Using these guidelines, at least a one-third reduction in mortality during the seven years following detection of breast cancer should be achieved, such as has been accomplished by the mass screening program of the Health Insurance Plan of Greater New York, reported by Strax.[1]

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Dr Jerome Urban[2] reported that "the breast salvage obtained in patients with 'minimal' breast cancers . . . was 95% survival at ten years" and it has been projected that these cases have a 90%, 20-year relative survival rate.[3] In another study,[4] Henry Leis, Jr, reported a 97.1% ten-year survival rate for patients with Stage 0 cancers (less than 1 cm in size.) These impressive results were obtained by incorporating mammography and physical examination.

For women 40 and over, or when indicated, mammography or xeromammography, following the clinical examination, should be mandatory for complete evaluation. They have proved to be integral and necessary steps in the detection of early clinically occult breast cancers. The medical profession now has the ability and techniques to attain a better cure rate for minimal breast carcinoma, but only with better communication and teamwork will we be able to utilize these techniques to their fullest potential.

—RAUL MATALLANA, MD
Department of Radiology
UW Center for Health Sciences
Madison, Wisconsin 53706

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3. Moskowitz M: *JAMA*, 238:213, 1977.
4. Leis HP Jr: Diagnosis of breast cancer, *Ca-A Cancer Journal for Clinicians*, 27: 209-232, 1977.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

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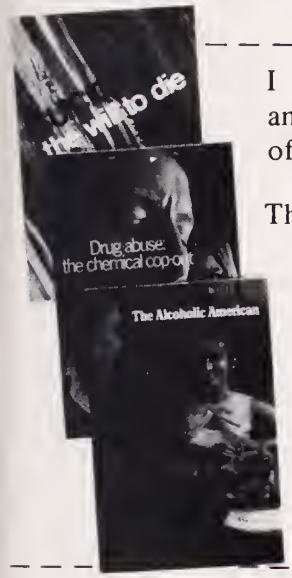

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SMS confronts State on T-19 handling of MD claims

Challenging the State Department of Health and Social Services Secretary Percy's report that EDS (Electronic Data Systems-Federal, Inc) handling of T-19 claims to date has been "excellent," the State Medical Society told the State Senate Human Services Committee in November that claims processing since July 1 has been "erratic and inconsistent" and too often a case of "no pay or low pay."

Jordon Frank, MD, Beloit, SMS Physicians Alliance Commission vice-chairman, cited repeated personal experiences over the past four and one-half months of mispaid, underpaid, and duplicate payments of claims.

He called upon DHSS and EDS to immediately investigate the causes of these widespread failures in payments to physicians and clinics. He urged the Department to adopt the SMS/Clinic Managers proposals for the use of the AMA claim form and to give up use of its outdated claims coding system which results in improper payment of physicians.

He also asked EDS to clean up the eligibility certification mess and assume greater responsibility for handling "other insurance" coverage by T-19 recipients.

At hearing's end, Committee Chairman Senator Carl Thompson, Stoughton, asked the Society to send the details of its complaints to the Senate Committee for follow-up action. ■

Amphetamine ban constitutes "cookbook" approach, says SMS

The State Medical Examining Board's ban on most uses of amphetamines, effective November 1 as a new rule in the Wisconsin Administrative Code (see November issue, page 18), was not strongly opposed by the State Medical Society, but the Society has told the Board and the public that this ban was a shotgun approach when a rifle approach would have been preferable.

The Society fears that rules such as this constitute a "cookbook" approach that also has become popular with the Legislature on such issues as testing for metabolic diseases.

Violation of this rule could result in discipline, including loss of license. The State Medical Society has recognized that amphetamines are drugs with very limited medical use but with high potential for abuse. After the Controlled Substances Board of the State Department of Health and Social Services performed a study on one amphetamine product — biphetamine 20 — and found that 916,500 dosage units were purchased by Wisconsin residents in 1975 via 26 practitioners, the State Medical Society again emphasized its position that physicians limit the prescription and dispensing of amphetamines to recognized conditions where these drugs are indicated. ■

Governor's race: Carley first to announce

David Carley recently became the first person to announce his candidacy for the Democratic nomination for governor. Printed here is Carley's statement to SMS physicians on the issue of health care in Wisconsin. As other individuals formally announce their candidacies for statewide office, SMS will solicit and print their comments.

* * *

"I have been asked to state what significance my candidacy for the governorship will have for Wisconsin physicians. First, I believe my candidacy is important to Wisconsin physicians because they are, first and foremost, Wisconsin citizens. All citizens look to our political leaders for the most diligent stewardship of our public resources, manpower, financial and natural resources. The correct allocation of resources and the proper application of laws applied fairly with equality and equity, is the principal duty of political leadership. I think 25 years of varied and successful experience in managing people and finances, in both the private and public sectors, is one of the principal reasons people have given for supporting my candidacy.

More specifically, the medical community is aware of my involvement and commitment to a rational and fair public and professional policy with regard to health care in Wisconsin. I have publicly rejected the political rhetoric arguing that high health-care costs are due to conspiratorial actions. Rather, I have said, they are due to structural deficiencies caused in part by incredible demands by the public for quality health-care services; a well meaning but unwieldy regulatory bureaucracy; and, the lack of personal accountability of citizens in health care. Altogether, these produce unacceptably high costs.

To be sure, there are a few cases of irresponsible health-care providers, and these must be removed. Our task as a society, and my task as a candidate for public office, must be to insure that all members of the population can have good access to health care; stronger and diligent efforts toward cost-containment; greater incentives toward personal accountability for good health care; and, more equitable distribution of the quality medicine everyone agrees we have in Wisconsin." ■

Dane County Jail joins Jail Health Program

The Dane County Jail has been accepted as an applicant for the next round of accreditations of the Jail Health Program carried out by the State Medical Society of Wisconsin. The next round of accreditations will be completed by February 1978.

Under the accreditation process, the jail staff and SMS Jail Health Program staff work to formalize health related matters in jails and measure them against the AMA's Standards for Accreditation of Medical Care and Health Services in Jails.

The initial accreditation process in Wisconsin led to full accreditation for two years for the Eau Claire County Jail, and provisional accreditation for the Milwaukee County Jail in mid-August 1977. The Adams County Jail, which has been a participant in the project since its inception in January 1976, also will undergo an attempt at accreditation for early 1978. ■

SMS Variable Annuity

. . . Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.28 as of September 30, 1977. ■

Clinic Managers/SMS meet with EDS and DHSS on TITLE-19

Kurt Wendt, Rhinelander, chairman of the Board of Directors of the Wisconsin Clinic Managers Association, Inc., spoke to a full house November 9 at Society headquarters in Madison. This special meeting of Clinic Managers and the State Medical Society/Physicians Alliance Commission Medicaid Oversight Committee was called in order to develop a unified position, in conjunction with the State Medical Society, on three critical issues before medical group administrators and physicians of the State of Wisconsin: the Title-19 provider contract; title-19 reimbursement and related problems with EDS and the State Department of Health and Social Services; and acceptance of a statewide, uniform insurance claim reporting mechanism.

Approximately 75 clinic managers, several physicians, a representative of the Medical Society of Milwaukee County, and State Medical Society staff concluded the morning session with a strong stand for solidarity on the above issues.

After comments by Ralph Andreano, PhD, administrator of the State Division of Health, the afternoon was devoted to a problem-solving dialogue among Marty Preizler, director of the Bureau of Health Care Financing, and his staff; Jose Ofman, Medicaid Program director of EDS-Federal, Inc, and his staff; selected members of the Clinic Managers Association; Jordon Frank, MD, vice-chairman of the SMS Physicians Alliance Commission and chairman of the T-19 Oversight Committee; Earl Thayer, SMS secretary; and Paul Simms, director of the Society's Physicians Alliance Division.

The meeting was successful in terms of attendance, enthusiasm, and cooperation in seeking resolutions to the "medicaid mess," Secretary Thayer noted. Results of the meeting were: a better understanding and acceptance of what the T-19 contract (not expected to be offered until early 1978) does and its impact on Wisconsin physicians and administrators; and acceptance by the Clinic Managers Association of a uniform claim form for reporting insurance claims, not only for T-19 but also for all third-party payers. (The AMA-endorsed version has been adopted with appropriate changes in the first of a series of steps for its statewide use.)

The meeting also produced several important steps toward developing better working relationships with EDS and the Department of Health and Social Services such as: (1) acceptance of the concept of a uniform procedural and coding system to apply to Title 19 as well as other insurance claims; (2) a commitment from the State DHSS to help in the resolution of such problems as eligibility certification, a more equitable services and supplies coding system, and a method of review of physicians' profiles; (3) a commitment by the State and EDS to work with experimental billing procedures for insurance claims, including tape-to-tape; and (4) a willingness by EDS and the State to work with SMS physicians and clinic managers in an organized, expedient way on specific problems of reimbursement and communications that are plaguing providers of the State.

Regular meetings will continue between SMS/Clinic Managers, EDS and the State. The job is not yet complete, but for those attending the November 9 meeting, the consensus seemed to be that "things are looking up." ■

Governor vetoes chiropractic bill

Acting Governor Martin Schreiber, on November 22, vetoed Senate Bill 108 which mandated the inclusion of chiropractic services in every health insurance policy sold in Wisconsin.

SMS believes the veto represents an examination of the bill on its merits and not a political decision by the Governor.

The Governor said the bill posed two problems that the Legislature failed to address: (1) the potential cost of any mandated benefits, and (2) the "real public policy" of requiring these benefits in insurance policies. Schreiber also suggested that mandatory inclusion of chiropractic in insurance policies was inappropriate and such mandates are all too often a "special interest appeal from a particular group of providers."

Senate Bill 108 will now return to the State Senate for consideration in mid-January. A two-thirds majority is needed in both houses of the Legislature to override the Governor's veto. ■

PAC sends endorsements to Council on Nov 18

At its monthly meeting November 18, the SMS Physicians Alliance Commission recommended that the Council:

(1) Endorse the AMA uniform claim form as the standard form to be used in submitting claims to all third party carriers including Medicare and Medicaid.

(2) Approve statewide use of CPT-4 as the uniform procedure code for all claims.

(3) Approve use of HICDA as the statewide uniform diagnosis code in filing claims.

(4) Develop a uniform code for supplies and equipment used in physicians' offices to simplify and expedite processing.

(5) Formulate an advisory committee to work with the State Department of Health and Social Services to evaluate proposed policies on T-19 rules. ■

SMS opposes MD provisions, proposed psychotherapy rule

At the same hearing November 16, SMS Secretary Earl Thayer and George Arndt, MD, Neenah, speaking for the Wisconsin Psychiatric Association, opposed a plan to require MD and non-MD psychotherapists equally to obtain prior authorization for more than five hours of therapy sessions with a T-19 patient; and to include psychologists, social workers, psychiatric nurses, and a variety of counselors as "providers" of psychotherapy. ■

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SMS opposes proposed national guidelines

In comments sent to the Office of Planning, Evaluation, and Legislation-Health Resources Administration on November 18, the State Medical Society strongly opposed certain sections of the proposed National Guidelines for Health Planning, which appeared in the *Federal Register,* September 23, 1977.

These federal guidelines, if adopted, will become requirements that all Health Systems Agencies will have to meet in their Health Systems Plans within five years. A hospital that fails to meet the requirements within this time period may be forced to merge, close, or alter its services.

The Society's Commission on Health Facilities and Services, which drew up the Society's position, noted that hospitals under 100 beds and in rural areas will be particularly hard hit by the requirements. The full text of the comments follows:

General concepts

We believe that the draft of the National Guidelines for Health Planning abnegates the intent of Public Law 93-641 and the Congress in the sense that the planning law was constructed so as to provide a maximum input from the local communities represented by their Health Systems Agencies. It is our further belief that this draft of "Guidelines" further bypassed the State agency in its role of giving a general direction and guidance with the assistance of the Department of Health, Education, and Welfare as it oversees the functions of its State Health Systems Agencies.

The State Medical Society of Wisconsin was not in any way consulted in the development or promulgation of this draft of the National Guidelines for Health Planning. The State Medical Society of Wisconsin is unaware of any consultations with any medical association or group within the State of Wisconsin in assisting in the development of the September 23, 1977 draft of the National Guidelines for Health Planning. We feel that this omission on the part of the Department of Health, Education, and Welfare bypasses the specific direction called for in the law in Section 15.01 (c.).

The State Medical Society of Wisconsin and the State agency in Wisconsin have for the past several years been developing *standards* for review of institutional expenditures under Section 1122 of the Social Security Act. Very recently, the State Medical Society of Wisconsin has been instrumental in the construction, support, and passage of the Certificate of Need legislation in Wisconsin. We feel that the process utilized under Section 1122 and the administrative rule process required under the State Certificate of Need legislation provide a better mechanism for development of planning parameters in the review of institutional expenditures. The experience in Wisconsin under Section 1122 has been one of more openness and candor in recent years, and we look forward to the appeal mechanisms afforded under the administrative rule-making process in Wisconsin as contrasted with the attempt of the Department of Health, Education, and Welfare in this document to force a set of *standards* on the over 200 health systems agencies in this country.

The State Medical Society of Wisconsin feels it is a misnomer to call these "Guidelines" when the Secretary indicates that in order for a health systems plan to be in compliance, these will be the maximum levels accepted. The Society feels this is not consistent with the specific direction in Public Law 93-641 Section 1513(b)(2) where it calls for appropriate consideration of the recommended National Guidelines in the review by health systems agencies.

The State Medical Society of Wisconsin feels that if these "Guidelines" are established as they are proposed, that the efforts and funding through the Health Systems Agencies and the State agencies will be a largely superficial effort embodying an attempt by the Department of Health, Education and Welfare, whereby the local agencies are forced to accept the plan while having little or no voice in the *standards* under which they must conduct review.

The Wisconsin experience has been that we are working effectively toward a higher occupancy rate, while at the same time experiencing shorter lengths of stay and less hospitalization. These "Guidelines" will seriously set back the public and provider acceptance of health planning in Wisconsin as an open and free process, whereby the issues are decided on their merits under *standards* developed locally.

We are extremely concerned on the potentially adverse effect of the imposition of these *standards* on the rural hospitals in Wisconsin and the accompanying potential for many of those institutions to be closed within five years. Only recently in Wisconsin have we begun to realize the benefits of State and Federal efforts in developing and funding new family physician programs to hopefully reverse the trend of the loss of the rural community physicians. The facts are that physicians will not locate where they do not have access to a hospital in their community, or an adjoining community.

We find these *standards* entirely too specific while grossly inadequate in their attempt to provide methods to reflect local considerations. The comments preceding the "Guidelines" recognize the infancy of a statistical basis for health planning; and based on this comment, we question how the Department of Health, Education, and Welfare can in all honesty be as specific and tight as they are in these *standards.* We feel these standards rely entirely too much on judgmental decisions on the part of the Department of Health, Education, and Welfare as they perceive optimal conditions in occupancy, aggregate numbers, procedures, and accessibility.

Specific "Guidelines" comments

I. OCCUPANCY & BED RATIOS

These *standards* must reflect any medically justified exemption based on local and regional experience. A good example here would be a regional or statewide cancer treatment center where the ratio might be higher than normal, reflecting referrals for a specific treatment regimen. This *standard* must certainly call upon the Secretary to grant, once certain criteria have been met, a number of exemptions. The Secretary should be in the position of determining whether the criteria have been met, but not whether the exemption is medically warranted. The use of an 80% occupancy rate as a goal is an arbitrary decision based on the biased selection by the Department of Health, Education, and Welfare as to what they perceive as an optimal occupancy rate. We must not force the system to close existing hospitals within a short period of time when we already are systematically and orderly striving toward an increased occupancy rate. These *standards* must also consider the number of days that a hospital operates at maximum capacity. This is a crucial consideration in determining how many people are turned away during these times.

II. OBSTETRICS SERVICES

The State Medical Society of Wisconsin strongly objects to the inference that those individuals receiving obstetrical services in a low volume institution normally get a decreased quality of service. We find it surprising that these *standards* do not speak to the concern nationally of the rising trend in home deliveries—and the potential impact that the imposition of these *standards* would have if a number of small community obstetrical services were closed, with its accompanying potential for an increased incidence of home deliveries. Certainly deliveries in a hospital setting are a safer procedure than those delivered in the home.

III. PEDIATRICS SERVICES

The State Medical Society of Wisconsin feels that these *standards* show appalling lack of concern for the patient and the family. They do not adequately reflect the emotional trauma on a pediatric patient caused by the hospitalization process, this being further accentuated by distance from home. The Society feels further that it should be a local option as to the determination of the age of the pediatric patient versus the adult patient reflecting the supply of physicians and their professional expertise in each geographical area.

IV. NEONATAL INTENSIVE CARE

We firmly believe that the Wisconsin planning experience in neonatal intensive care system is by far superior to what is being called for in these *standards* and could potentially set Wisconsin back ten years. In the review of any neonatal intensive care occupancy rates, there is a serious concern as to whether the beds are being under-utilized or whether, indeed, we are experiencing a surplus of beds.

V. OPEN HEART SURGERY

These *standards* are unnecessarily rigid and do not reflect any potential for changing procedures and technology.

VI. CARDIAC CATHETERIZATION

These *standards* must be modified so that the Health Systems Agencies are not placed in a position of being forced by Federal requirements to sanction a high volume, low quality service, while condemning the high quality, low volume service. In short—these are poor "guidelines".

A crucial concern in this area is the acceptance of the cardiac catheterization results by the potential surgeon, not whether this service is located in the same institution. An excellent example in Wisconsin would be a cardiac catheterization program at Eau Claire, and the willingness of La Crosse or the Mayo Clinic physicians to accept these results as the basis of their open heart surgery, thus utilizing the appropriate role of the cardiac catheterization as a screening tool, while not necessitating duplication of this procedure.

VII. RADIATION THERAPY

These *standards* must reflect local cancer incidence levels for which in Wisconsin the data is readily attainable and could easily be adapted for planning purposes.

VIII. COMPUTERIZED AXIAL TOMOGRAPHY (CAT)

These *standards* must reflect changing technology. These machines, because of technology, differ greatly in cost; and this has an impact on the cost versus beneficial value. This must be a consideration in the determination of how many, and where, these machines are placed.

These *standards* must reflect the potential for a significant amount of down time in the operation of these highly sophisticated electronic devices.

The controversy of head versus head and body scanners must be addressed in some way, or at least guidance given to State agencies and Health Systems Agencies as they attempt to grapple with this problem.

The State Medical Society of Wisconsin feels that the use of 4,000 procedures is an unrealistic expectation of this developing science. We feel further that it is inappropriate for these *standards* to specify the methodology by which rates for charges are determined.

IX. END STAGE RENAL DISEASE

It is the opinion of the State Medical Society of Wisconsin that the Wisconsin Section 1122 experience in this area is what should continue to be the process utilized in this State.

The State Medical Society of Wisconsin recognizes that nationally there may exist an excess of beds as they are currently being utilized. We point out that this situation has developed over a period of years reflecting changing technologies which directly affect utilization and length of stay. Any attempt to rigidly and rapidly reduce the number of accessible beds in a relatively small geographical area is fraught with danger and based on an inexact science of projecting need and the accompanying supply. These "Guidelines" should be reworked, utilizing additional resources and input that are certainly available to the Department of Health, Education, and Welfare with significantly improved assurance it is not attempting a short-term savings while creating a system that cannot survive in the long run.

While the State Medical Society of Wisconsin remains opposed to these *standards* as proposed, we recognize the need for overall direction and guidance and stand ready to assist the State agency and the Department of Health, Education, and Welfare in the development of realistic goals to be worked toward over a well thought-out period of time.

—Approved by the Commission on Health Facilities and Services of the State Medical Society of Wisconsin on November 16, 1977. ■

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SMS physicians meet with Governor

On November 7, Roy B Larsen, MD, president of the State Medical Society; Jules D Levin, MD, president-elect; Paul S Haskins, MD, chairman of the SMS Council; Kenneth M Vistc Jr, MD, chairman of the Physicians Alliance Commission, and several other Physicians Alliance commissioners met with Acting Governor Martin Schreiber to discuss legislation concerning health care.

The SMS physicians urged the Governor to veto the chiropractic bill, SB 108, which he did on November 22 and is reported elsewhere in this issue; informed the Governor of several SMS-supported bills dealing with professional liability that should come before him next spring; and discussed the initiatives that the Society is taking in the area of cost-containment in health care.

Governor Schreiber requested future meetings with SMS physicians on a more regular basis. ▪

Doctor, have you renewed your medical license?

Physicians have until December 31 to renew their state license to practice without paying a late filing or penalty fee, the State Medical Examining Board has advised the SMS.

And there's been an increase in the renewal fee, too. The fee is now $30 for two years.

This fee change is a provision in the 1977-79 state budget bill which became effective July 1, 1977. The budget bill changed the licensing structure fee for *all* licenses issued by the State of Wisconsin.

Previously, physicians paid a $200 initial examination fee for state licensure and an $8 yearly license renewal fee. All the physician license fees then went directly to the State Medical Examining Board. As of July 1, 1977 the fees for *all* state licenses go to the State Department of Regulation and Licensing which then distributes the fees to the various regulatory boards.

The initial examination fee for *all* state licenses is now $50 and a $30 license renewal fee is charged every two years. So in effect, the license renewal fee for physicians has doubled and the initial examination fee has decreased by $150.

In addition, individuals who are less than 30 days late in sending in their license renewals, which are due January 1, 1978, will be charged an extra $5. For late license renewals of more than 30 days, a $25 penalty will be charged. ▪

COUNTY SOCIETIES

WAUKESHA

Dr Richard Quintiliani of Hartford, Conn, spoke before 65 members and guests of the Waukesha County Medical Society at its October 5 meeting in Waukesha on the subject of "Infectious Diseases and New Antibiotics." Members also heard a panel discussion on "Child Abuse."

LINCOLN

The Lincoln County Medical Society held elections of new officers for the year 1978 at its annual meeting in September. They are MDs Jerome S Mayersak, Merrill, president; Nunilo L Bugarin, Tomahawk, vice-president; and Muhammad Y Ahmad, Merrill, secretary-treasurer. James S. Janowiak, MD, Merrill, was elected delegate to the State Medical Society and Geoffrey C Kloster, MD, Merrill, alternate delegate.

SAUK

Election of officers for the year 1978 was held November 8 as follows: president—David P Kuter, MD, Baraboo; secretary-treasurer—Donald W Vangor, MD, Baraboo; delegate—Ihor Galarnyk, MD, Spring Green; alternate delegate—Gerald J Holmen, MD, Baraboo. President-elect is John Koch, MD, Prairie du Sac.

BROWN

Forty-two members of the Brown County Medical Society were present for the October 13 meeting in Green Bay.

During the business session, President John M Mills, MD, Green Bay, reported that the Society's nominee to fill any opening on the Northeastern Wisconsin Health Systems Agency would be Bruce C Bressler, MD, Green Bay. Doctor Mills also noted that physician participation in the HSA has been good with MDs John H Draheim, Green Bay, Bernard P Waldkirch, DePere; Joseph B Grace, Green Bay; and Rolf S Lulloff, Green Bay.

The Society considered a proposal of Charles C Smith, MD, Green Bay for establishing a committee to encourage and recruit other physicians for Green Bay. Formation of the committee was deferred until the pros and cons of such a recruitment effort could be evaluated.

The Society's program featured a slide presentation of the health systems agency (HSA) by Michael Brozek, field consultant of the State Medical Society's Physicians Alliance Division.

The slide show, produced by the SMS Communications Department, indicated that there were 200 HSAs in the country and that they were a regional agency to improve health care. Mr Brozek noted that early voluntary systems had been failures and that the current HSA is a mandatory federal requirement. He outlined the makeup of the HSA boards and the work that the State Medical Society is doing to work with them.

Mr Brozek also indicated the relationship between the HSA, the state government, and the US Dept of Health, Education, and Welfare. He further noted that the SMS has an HSA task force pilot-project in Winnebago County and that this project may form the basis for other HSA task forces throughout the State.

Mr Brozek emphasized the need for the physician task force to anticipate needs and to work effectively with the HSA board, and that physicians must learn to "play the game." He said that the SMS is ready to assist physicians in their associations with local HSAs.

During a question and answer session following the slide presentation, Herbert F Sandmire, MD, Green Bay, commented that physicians must discover things that need to be done and do them, that physicians must in effect "get the jump" on the health-care planners and meet the needs. Doctor Sandmire is chairman of the State Medical Society's Commission on Public Information.

WOOD

Thirty-four members and four guests attended the October 20 meeting of the Wood County Medical Society in Marshfield. Russell F Lewis, MD, Marshfield, Fourth District Councilor, reported on activities of the Council. Marvin Stromer and Michael Brozek, field consultants of the Physicians Alliance Division of the State Medical Society, presented a program on the Health Systems Agencies. ▪

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of Oct 17, 1977

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

BARRON-WASHBURN-BURNETT

Quenan, James P, 209 4th Ave, West, Shell Lake 54871 (1945, Regular, General Surgery)

BROWN

Buck, Charles E, 1745 Dousman, Green Bay 54303 (1948, Regular, Internal Medicine)
Fergus, Peter A, 3319 Camelia Ct, Green Bay 54301 (1944, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)
Shrake, John F, 128 Bequpre, Green Bay 54301 (1948, Regular, Internal Medicine)
Wigg, Norman P, 1551 Dousman St, Green Bay 54303 (1932, Regular, Family Practice, Certified)

CLARK

Algan, A Mitat, 400 Mill St, Loyal 54446 (1929, Regular, Internal Medicine)
Delorme, Robert W, 216 Sunset Blvd, Neillsville 54456 (1948, Regular, Family Practice)

DANE

Ahmad, Khalil, Mt Sinai Hospital, Calif Ave at 15th St, Chicago, IL 60608 (1942, Resident, Internal Medicine/Cardiovascular Diseases)
Arenberg, Irving K, 1300 University Ave, Madison 53706 (1941, Regular, Otorhinolaryngology, Certified)
Bryan, Albert R, 1 S Park St, Madison 53715 (1934, Regular, Internal Medicine)
Greer, James A, 30 S Henry St, Madison 53703 (1943, Regular, Otorhinolaryngology)
Holt, Robert E, 2725 Marshall Ct, Madison 53705 (1945, Regular, Psychiatry)
Rolnick, David J, 30 S Henry St, Madison 53703 (1943, Regular, Orthopedic Surgery)
Rudman, Shewin M, 30 S Henry St, Madison 53703 (1948, Regular, Obstetrics and Gynecology)

EAU CLAIRE-DUNN-PEPIN

Brown, Thomas E, 733 W Clairemont Ave, Eau Claire 54701 (1945, Regular, General Surgery)
Decesare, William F, 2920 Sherwin Ave, Altoona 54720 (1947, Regular, Orthopedic Surgery)
Kimmel, Marco T, 2712 Stein Blvd, Eau Claire 54701 (1930, Regular, Psychiatry)
Leavitt, James R, 836 Richard Dr, Eau Claire 54701 (1948, Regular, Orthopedic Surgery)
Menghini, Peter P, 727 Kenney Ave, Eau Claire 54701 (1945, Regular, General Practice)
Resar, Roger K, 1111 Mulberry Dr, Altoona 54720 (1946, Regular, Pulmonary Diseases/Internal Medicine, Certified-IM)
Schmehl, R Malcolm, Rte 1, Box 171, Durand 54736 (1947, Regular, Family Practice, Certified)
Simske, Clifford J, 2103 Heights Dr, Eau Claire 54701 (1937, Regular, Psychiatry/Obstetrics and Gynecology, Certified-OBG)

FOND DU LAC

Bartonek, Victoria D, PO Box 134, Ripon 54971 (1937, Regular, Family Practice)
Chamberlain, Daniel, 80 Sheboygan, Fond du Lac 54935 (1946, Regular, Internal Medicine/Pulmonary Diseases Certified-IM)
Chang, Henry Ta-Shen, 807 E Division St, Fond du Lac 54935 (1946, Regular, Anesthesiology)

KENOSHA

Zarka, Koussay M, Larch St, Silver Lake 53170 (1931, Regular, General Practice/Obstetrics and Gynecology)

LACROSSE

Kwong, Roger W, 1836 South Ave, LaCrosse 54601 (1947, Regular, Internal Medicine, Certified)
Steingraeber, Paul H, 815 S 10th St, LaCrosse 54601 (1946, Regular, Obstetrics and Gynecology)

MARATHON

Klemm, Frederick A, 400 E Thomas St, Wausau 54401 (1945, Regular, Emergency Medicine)
Monaco, Joseph M, 400 E Thomas St, Wausau 54401 (1948, Regular, Pediatrics)
Osband, Gerald E, 400 E Thomas St, Wausau 54401 (1948, Regular, Family Practice)
Sack, J Garry, 614 First St, Wausau 54401 (1946, Regular, Otorhinolaryngology)
Waldman, Arthur M, 400 E Thomas St, Wausau 54401 (1948, Regular, Family Practice)
Witteman, George J, 614 First St, PO Box 599, Wausau 54401 (Ophthalmology)
Zickerman, Philip M, 400 E Thomas St, Wausau 54401 (1943, Regular, Urological Surgery)

MILWAUKEE

Auger, Gerald E, 6745 W Wells St, Milwaukee 53213 (1939, Regular, Internal Medicine)

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Bloch, Winston N, Jr, 2040 W Wisconsin Ave, Suite 707, Milwaukee 53233 (1942, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)
Caine, Marc R, 2500 Lincoln Ave, Milwaukee 53215 (1948, Regular, Internal Medicine)
Daniel, Alan, 2025 E Newport Ave, Milwaukee 53211 (1942, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)
Flesch, James R, 4611 N Oakland Ave, Milwaukee 53211 (1944, Regular, Orthopedic Surgery)
Garg, Anil K, 3238 S 16th St, Milwaukee 53215 (1937, Regular, Internal Medicine/Cardiovascular Diseases)
Gilson, Ian H, 788 N Jefferson St, Milwaukee 53202 (1948, Regular, Internal Medicine)
Gorens, Sherwood W, 210 W Blackhawk Rd, Milwaukee 53217 (1920, Regular, Anesthesiology / Internal Medicine, Certified-IM)
Harvey, William D, 1424 N 121st St, Wauwatosa 53226 (1942, Resident, Radiology)
Huxley, Eliot J, 1218 W Kilbourn Ave, Suite 207, Milwaukee 53233 (1947, Regular, Pulmonary Diseases/Internal Medicine, Certified-IM)
Machi, Anthony T, 1700 W Wisconsin Ave, Milwaukee 53233 (1947, Resident, Psychiatry)
McInerney, Gerald T, 2400 S 90th St, West Allis 53227 (1931, Regular, Cardiovascular Diseases/Internal Medicine)
Minikel, James E, 5032 W Forest Home Ave, Milwaukee 53219 (1943, Regular, Orthopedic Surgery)
Rabenn, William B, 7607 N Longview, Milwaukee 53209 (1928, Regular, Anesthesiology, Certified)
Soo, K Kwang, 111 E Wisconsin Ave, #1715, Milwaukee 53202 (1942, Regular, Psychiatry)
Sovine, David L, 1200 E Capitol Dr, Shorewood 53211 (1946, Regular, Psychiatry, Certified)
Willson, D MacLean, 5252 N Bay Ridge Ave, Milwaukee 53217 (1943, Regular, General Surgery, Certified)

ONEIDA-VILAS

Hertel, Bruce F, Box 567, Lake Tomahawk 54539 (1947, Regular, Pathology, Certified)
Schell, Charles A, PO Box 549, Woodruff 54568 (1924, Regular, General Practice)

OUTAGAMIE

Chessin, Henry, 424 E Wisconsin Ave, Appleton 54911 (1945, Regular, Radiology / Therapeutic Radiology, Certified-R)
Homburg, Nancy J, 401 N Oneida St, Appleton 54911 (1949, Regular, Family Practice)
Mc Kee, Charles A, 1523 S Madison St, Appleton 54911 (1946, Regular, Family Practice)
Stewardson, Richard, 900 E Grant, Appleton 54911 (1946, Regular, General Surgery/Cardiovascular Surgery, Certified-GS)

RACINE

Lippman, Harry H, 807 16th St, Racine 53403 (1942, Regular, Neurological Surgery/Neurology, Certified-NS)
Yllas, Santiago L, 2908 Taylor Ave, Racine 53405 (1937, Regular, Family Practice)

TREMPEALEAU-JACKSON-BUFFALO

Christianson, Paul B, 601 W Adams St, Black River Falls 54615 (1942, Regular, Thoracic Surgery/General Surgery, Certified-TS)

WAUKESHA

Berman, Gerald N, 1111 Delafield St, Waukesha 53186 (1946, Regular, Internal Medicine)

There were 131 physicians removed from membership for delinquent dues in 1977.

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DANE

Albright, Edwin C, Solon Springs, to 3901 Euclid Ave, Madison 53711
Biek, Richard W, Madison, to 1029 North Jackson, St, Milwaukee 53202
Elias, Peter H, Stoughton, to 564 Lake St, Auburn, ME 04210
Tu, Her-Lang, Madison, to 204 Woodland Dr, Waupun 53963
Wallace, Charles C, Madison, to 401 N Oneida St, Appleton 54911

EAU CLAIRE-DUNN-PEPIN

Gericke, Julius T, Jr, Eau Claire, to 7701 E Thunderbird Rd, Scottsdale, AZ 85254

GREEN

Kamstra, Egbert, Monroe, to 1825 West Cottage St, Stevens Point 54481

LANGLADE

Curran, William P, Deerbrook, to 2821 SW 4th St, Boynton Beach, FL 33435

MARATHON

Eghbali, Hassan, Wausau, to 2040 W Wisconsin Ave, Milwaukee 53233

MILWAUKEE

Hitz, John B, Wauwatosa, to 32265 West Oakland Rd, Nashotah 53058

RACINE

Herrmann, Anthony A, Racine, to 54 Wardell Ave, Rumson, NJ 07760

ROCK

Farnsworth, R W, Janesville, to 301 North Ocean Blvd, Pompano Beach, FL 33062

WINNEBAGO

Beatty, Samuel R, Oshkosh, to 4700 Ocean Beach Blvd, Cocoa Beach FL 32931
Gammell, Gerald H, De Pere, to 6224 Belmore Lane, Hopkins, MN 55343
Meli, James V, Oshkosh, to 4741 West Blvd, Naples, FL 33940
Steen, Marvin H, Oshkosh, to PO Box 1171, Carefree, AZ 85331

WOOD

Chotiwutvinit, P, Marshfield, to 1816 First Ave, Cedar Rapids, IA 52402
Garrison, Rogers E, Wisconsin Rapids, to 500 Park Blvd, Venice, FL 33595
Williamson, George D, Marshfield, to 1900 Gordon Cooper, Shawnee, OK 74801

DEATHS

Golden, Peter B, Dane County, Sept 3, 1977
Ford, John L. Brown County, Sept 11, 1977
Adamkiewicz, Joseph, Milwaukee County, Sept. 17, 1977
Meyer, Ovid O, Dane County, Sept 22, 1977
Koch, Martin J, Milwaukee County, Sept 23, 1977
Hibma, Otto V, Dane County, Oct 7, 1977 ■

OBITUARIES

◈County, State, AMA Members

Ernst H Carstens, MD, 84, former Rib Lake physician, died June 18, 1977 in Medford. Born Nov 23, 1892 in Davenport, Ia, Doctor Carstens graduated from Loyola University Medical School, Chicago, in 1915. Surviving are his widow, Mildred; a daughter, Mrs June Klickman, Rockford, Ill, and a son, Kenneth, Manitowoc.

◈ **Martin J Koch, MD,** 94, Milwaukee, died Sept 23, 1977 in Milwaukee. Born June 23, 1883 in Ashton, Wis, Doctor Koch graduated from Marquette University School of Medicine in 1907. Doctor Koch practiced medicine in the Milwaukee area for over 50 years and was an associate professor at Marquette University School of Medicine, now the Medical College of Wisconsin. Surviving are a brother, Dr Anthony J, Whitefish Bay, and a sister, Louise Gaukel of Lodi, Wis.

◈ **Carl J Weber, MD,** 88, Sheboygan physician and surgeon for 43 years, died Oct 14, 1977 in Sheboygan. Born Dec 21, 1888 in Brookfield, Wis, he graduated from Rush Medical College in 1922. Doctor Weber retired from medical practice in 1967. Surviving are one son, Dr John of Milwaukee, and a daughter, Mrs Marion Lusier of Madison. ■

Wausau Medical Center

. . . opened its new $4.3 million facility, located near the new hospital west of the Employers Insurance complex, in October. Designed for expansion, the building has facilities for 65 to 67 physicians. The center now has 51 physicians. Gene Oestreich, administrator, said the new structure has 90,000 square feet, three times that of its old building, and has space for expanded laboratory, x-ray, audiology, and electrocardiogram departments. He said the new Center expects to serve both the patients' and the doctors' needs more quickly and efficiently. The Center's board of directors includes Kenneth L Day, MD,* president; Thomas A Starkey III, MD,* vice-president; David K Aughenbaugh, MD;* Robert C Kaupie, MD;* Kenneth R Knutson, MD;* Edgar B Koschmann, MD;* W George Locher, MD;* and Richard C O'Connor, MD,* all of Wausau.

Pediatric Journal Club

. . . has been formed by Washington County pediatricians to stimulate continued reading in the field of pediatric medicine. Although there are many different ways to run a journal club, this club has decided on a unique format. At its monthly meetings, the pediatricians will deal with a specific problem in pediatrics with each of the physicians contributing one or more articles relating to that field. The October meeting dealt with hormonal therapy of growth problems. Members are MDs, Jerold J Beerends and Simon Tan,* West Bend; Chungki Lee,* Ronald Gritt,* and Parnell Donahue* of Hartford.

UW Dept of Anesthesiology

. . . Chairman S Craighead Alexander, MD* has announced the addition of a new physician to the department staff. Rick S Schwettmann, MD has been appointed assistant professor of anesthesiology and coordinator of the pain clinic located in University Hospitals, Madison. Doctor Schwettmann is a graduate of the Southwestern Medical School, Dallas, Tex. His residency training was taken at the University of Washington in Seattle. He previously was a consultant at the Mayo Clinic in Rochester, Minn.

In making the announcement Doctor Alexander explained that the pain clinic is staffed by a team of physicians from the Departments of Anesthesiology, Internal Medicine, Neurological Psychology, and Physical Medicine and Rehabilitation.

The team sees patients with chronic pain and cancer pain during their hospital stay, as well as on an outpatient basis, Doctor Alexander stated.

Skemp-Grandview Clinic, SC

. . . and LaCrosse Clinic, Ltd in November announced plans to merge and become the "Skemp-Grandview-LaCrosse Clinic."

According to Donald B Comin, MD,* Skemp-Grandview president, the reason for the merger is "better utilization of personnel, medical services and facilities." The merger will create a clinic corporation of 47 physicians specializing in 19 medical areas. The corporation will be spread throughout five buildings: two in LaCrosse, one in West Salem, one in Holmen, and one soon to be constructed in LaCrescent, Minn.

The announcement to merge as a single corporation is the result of four years of planning, Doctor Comin said.

Walter J Vallejo, MD,* president of LaCrosse Clinic, stressed that the merger will have no significant effect on patients seeing their regular physicians at either clinic.

Doctor Comin said the corporation itself will be one of the largest in Wisconsin. "However, because we're scattered throughout the area, we are actually a group of moderately small clinics." He added that there are no plans at the present time for a physical merger of the two main clinic buildings in LaCrosse.

A new board of directors and officers will be elected to govern the new corporation.

Julius Wetsch is presently the administrator of Skemp-Grandview Clinic and will continue as administrator of the new corporation. Leroy Gagermeier is presently the manager of LaCrosse Clinic, but will become associate administrator of the new corporation.

PHYSICIAN BRIEFS

Danilo Oliveros, MD

. . . Medford, recently began medical practice at the Prentice Medical Facility. Doctor Oliveros, who is associated with the Medford Clinic, graduated with the Far Eastern University in the Philippines and served an internship at St Elizabeth Hospital, Elizabeth, New Jersey.

Gary Katz, MD

. . . Stevens Point, recently joined the medical staff of the Rice Clinic in the Department of Urology. He graduated from McGill University Medical School, Montreal, Canada, and served his residency at the Mayo Graduate School of Medicine in Rochester, Minn. He also completed a general surgery residency at Jewish General Hospital, Montreal.

John Kirchner, MD

. . . Marshfield, has become associated with the Marshfield Clinic in the Department of Internal Medicine. A specialist in gastroenterology, Doctor Kirchner received his medical degree from Loyola University Medical School, Chicago. His internship and residency were served at Chelsea Naval Hospital, Boston, and he completed a fellowship at the Philadelphia Naval Hospital. Prior to joining the Clinic staff, Doctor Kirchner served on the medical staff of the National Naval Medical Center, Bethesda, Md. He also was attending physician for the liver unit at the National Institute of Health and with the internal medicine service at the VA hospital in Washington, DC.

Richard L Buechel, MD*
John V Flannery III, MD*
Leonard H Wurman, MD*

. . . Wausau, recently were named fellows of the American College of Surgeons in Dallas, Tex. Doctor Buechel is associated with the Bone and Joint Clinic; and Doctors Flannery and Wurman are associated with the Ear, Nose and Throat Association.

Thomas Jackson, MD

. . . Plymouth, recently opened his office for the practice of general medicine. A 1976 graduate of the Medical College of Wisconsin, Milwaukee, he served his internship at Kern Medical Center, Bakersfield, Calif.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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David Pringle, MD*

. . . of the Department of Internal Medicine, Rice Clinic, Stevens Point, recently began a fellowship in nephrology at Mt Sinai Medical Center, Milwaukee. After his fellowship, he will return to the Clinic of which he has been a member of the medical staff since 1969.

Reuel Martinson, MD

. . . Sister Bay, has joined the emergency room medical staff at Oconto Falls Community Memorial Hospital. Doctor Martinson graduated from the University of Minnesota Medical School and received his internship at Northwestern Hospital, Minneapolis, Minn. His residency training was taken at the University of Minnesota.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF NOVEMBER 1977

1 Dane County Medical Society Board of Trustees
2 SMS Commission on Mediation and Professional Ethics
2 Title 19 Provider Groups
4 Maternal Mortality Studies
5 SMS Uniform Claim Form Development Committee
7 SMS Physicians Alliance Commission
7 SMS Medical Defense Committee
7 WisPRO Orientation
8 WisPRO Orientation
9 Physical Therapy-MD Ad Hoc Committee of the SMS Commission on Health Facilities and Services
9 WisPRO Orientation
9 Wisconsin Clinic Managers on T-19 Provider Problems
10 WisPRO Orientation
11 SMS Finance Committee
11 SMS Realty Board of Trustees
11 WisPRO Orientation
14 Madison Orthopedic Society
15 WisPRO Advisory Group
16 WisPRO Executive Committee and Board of Control
17 Wisconsin Council of Professions, Inc
17 SMS Commission on Health Facilities and Services
17 SMS Committee on Aging
18 SMS Medical Defense Committee
18 SMS Physicians Alliance Commission
29 H 24 Steering Committee

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parenthesis.

Marvin L. Hinke, MD*

. . . Marshfield Clinic radiologist, recently was elected to the Board of Censors and Directors of the Wisconsin Radiologic Society. Doctor Hinke has been on the medical staff of the Marshfield Clinic since 1963. He also has been a member of the clinical staff, Department of Radiology, University of Wisconsin Medical School, Madison. He is immediate past president of the Radiologic Society.

Peter Midelfort, MD*

. . . Eau Claire, recently received the Luther Hospital Good Samaritan Award. A surgeon, Doctor Midelfort served as vice-president of Luther's board from 1947 - 1955. He is a graduate from Harvard Medical School in Boston. During World War II he served in the US Army Medical Corps and from 1929 - 1966, he was preceptor for the University of Wisconsin Medical School, Madison. Doctor Midelfort retired from active medical practice two years ago.

Stephen J Carlson, MD*

. . . Shell Lake, recently opened his medical clinic in Spooner. He graduated from Northwestern University Medical School, Chicago, and served a family practice residency in Farmington, New Jersey. He also served two years in the United States Navy. He will spend time in Duluth each week where he is an instructor in the family practice residency program there.

Heinz Vogel, MD

. . . medical director of the Columbia County Guidance Center, Portage, recently offered his services, on a part-time basis, at the Adams County Unified Board. A native of Germany, he obtained his medical degree from Frankfort Medical School, Germany, and completed his internship and residency in the United States.

Alan B Fidler, MD*
Kenneth Klein, MD

. . . Milwaukee, have joined the medical staff of St Luke's Hospital, Racine, in the Department of Radiology. Doctor Fidler has been the director of the Department of Radiation Therapy at St Luke's Hospital, Milwaukee, since 1957; and Doctor Klein did his residency in the Department of Radiation Therapy at University Hospitals in Madison. They are members of the medical staff of Radiation Oncology Associates, Milwaukee.

Peter P Menghini, MD

. . . recently became associated with the Eau Claire Anesthesiologists, Ltd. Doctor Menghini graduated from Creighton University Medical School and served his internship at US Naval Hospital, Camp Pendleton, Calif. His residency was taken at the University of Iowa.

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A Series of Health Education

. . . programs has been developed by WHA-TV in conjunction with the Department of Continuing Medical Education, UW-Extension, Madison. The two to four minute programs are aired daily throughout the State on the Wisconsin Educational Television Network.

These shows, called "Health-Time," feature C Peter Erskine, MD who discusses general health issues such as home and recreational safety, first aid, cardiovascular fitness, cancer detection, and the like.

In addition to this, Doctor Erskine is heard each Tuesday morning between 6:00 and 7:00 over the Public Broadcast radio stations in southern Wisconsin. A commentator from WHA Radio questions Doctor Erskine about a current medical topic such as food additives, immunization risks, physical fitness, and the like.

Doctor Erskine recently completed his Pediatrics residency at the University of Wisconsin Hospitals, Madison, and has joined the faculty of the Department of CME, UW-Extension.

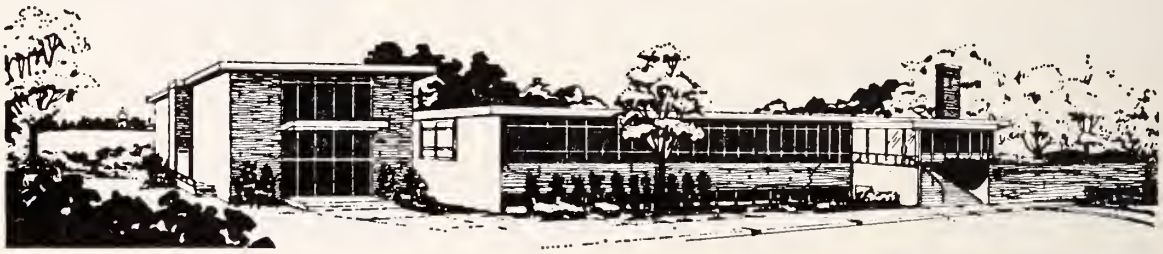
Rock Sleyster Scholars

. . . for 1977 have been announced by the American Medical Association Education and Research Foundation (AMA-ERF). The 16 one-year scholarships, totaling $32,000, have been awarded to the medical students on the basis of scholarship, financial need, and demonstrated interest in psychiatry, according to Hubert A Ritter, MD, AMA-ERF president.

Doctor Ritter said that this scholarship program was made possible by a $380,000 bequest of the late Mrs Clara S Sleyster of Shorewood, Wisconsin, establishing a memorial fund to honor her husband, Rock Sleyster, MD, president of the American Medical Association in 1939-1940.

Among the scholars is Thomas J Spencer, 26, of the University of Wisconsin, Madison.

Doctor Ritter said the Rock Sleyster Memorial Fund provides that scholarships be awarded to United States citizens enrolled in AMA-approved American or Canadian medical schools that grant MD degrees. Each school is invited to submit one nominee annually, normally from a student about to enter his final year of the curriculum.



STATE MEDICAL SOCIETY OF WISCONSIN

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SERVICES TO MEMBERS

- Socio-economic Representation
- Socio-economic Communication: Leaders' Letter (limited)
- Public Relations
- Wisconsin Work Week of Health
- Legislative Representation
- Legislative Communication: Capitol Week (limited)
- Retirement (Keogh) Plan
- Auto Leasing Plan
- Governmental Agency Contacts
- Medical Economic Advice
- Medicolegal Consultation
- Health Educational Activities
- Film Service
- Health Careers Information
- Speakers Service
- Voluntary Health Agency Contacts
- Student Loans
- Grievance Services
- Executive Office Services
- Wisconsin Medical Journal
- Medical Green Sheet
- Accidental Death and Dismemberment Insurance
- Life Insurance
- Disability Income Protection
- Business Overhead Insurance
- WPSIC—Blue Shield Health Insurance
- Annual Meeting
- Continuing Medical Education Programs
- Physician Placement Services

WANTED: GENERAL/FAMILY practitioner to practice in an excellent location providing service to numerous communities in the hospital's service area. Group practice optional. Terms negotiable plus living in a growing area with cultural and recreational advantages. Further details call or write: J L Schumacher, Administrator, Calumet Memorial Hospital, Chilton, Wis 53014. Tel: 414/849-2386. 11-12/77, 1-4/78

SEVEN PHYSICIAN (4 FAMILY Practice) incorporated group in Green Bay, Wis, seeking family physician. Competitive salary and clinic package plus living in a growing area with cultural and recreational advantages. Please contact Mr Jeff Rosemann, Business Manager, 1751 Deckner Ave, Green Bay, Wis 54302. 11tfn/76

FAMILY PRACTITIONER/GENeral practitioner. Would you be interested in practicing medicine at one of the most unique hospitals in the midwest? Family Hospital, in marvelous Milwaukee, offers the nationally known New Life Center for obstetrics, award-winning nursing care, greater freedom of privilege for family practitioners, and competitive benefits. Write Family Hospital, Administrator of Communications and Development, 2711 West Wells, Milwaukee, Wis 53208. p11-12/77,1/78

FAMILY PHYSICIAN: OPPORtunity for one or two in Northern Wisconsin resort town of Eagle River. New clinic facility next to hospital for four to six physicians to open June 1977. Drawing area includes entire Vilas County, parts of Oneida, Forest counties plus a large tourist population. If interested contact: Charles E Reevs, Admin, Eagle River Memorial Hospital, Eagle River, WI 54521. Tel: 715/479-4456. 4tfn/77

MEDICAL FACILITIES

OFFICE FACILITIES WITH COMplete laboratory and x-ray for general practitioner, internist or OB-GYN located in Medical Arts building, Southwest suburb of city of Green Bay, Wis. Easy access to three hospitals. G E LeMieux, MD, PO Box W-200, De Pere, Wis 54115. 10-12/77

FOR SALE: ENTIRE OFFICE AND medical equipment of deceased doctor who was engaged in general practice and surgery in the Village of Waterford, Racine County, Wis. Office used by doctor available for lease. Call 414/539-2868. g9tfn/77

MEDICAL OFFICE FURNITURE: Examining table, upright cabinet, equipment table, desk with chair and 6 wooden arm chairs—used in waiting room. Will contribute to anyone who will pay the cost of moving them. Contact Mrs John M Albino, 438 Shoreland Dr, Racine, Wis 53401. g8tfn/77

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77 ■

NEW MEDICAL-DENTAL OFfices for lease: Opportunity to plan and design your new office. Designs for offices 650 to 4000 square feet. Spacious, modern facility now available in convenient Hales Corners. For appointment call 414/271-5017. p12/77,1-2/78

OFFICE AVAILABLE FOR LEASE for general physician or related specialty. 7400 West Brown Deer Road, Milwaukee—on North Ridge Lakes—new building nearing completion, will partition to suit. AC 414/445-3329 or AC 414/352-0809. 11tfn/77

RETIRED GENERAL SURGEON'S professional equipment for sale. Can be purchased in entirety or separately. Call 608/846-5661 between 8:30-10 PM. 8/77*

FOR RENT: PROFESSIONAL building has 1600 sq ft of office space available. Excellent location on Waukesha's southside. Tel: 414/544-4407. 12tfn/77

OFFICE SPACE AVAILABLE: New professional building—West Bend, Wis. 30 miles north of Milwaukee. Located directly across from only hospital in area. Individual offices presently occupied by two orthopedic surgeons, one ophthalmologist, one OB/GYN, one family practice group (4 MDs), three dentists, and pharmacy. Two suites available—1200 sq ft and 800 sq ft. Will develop to your requirements. Ideal for any medical specialty—internist, surgeon, dermatologist, urologist, pediatrician, etc. Write or call: Management Committee, Oakbrook Medical Complex, 1201 Oak St, West Bend, Wis 53095. % R. H. Schacht, DDS, 414/334-5151. 12/77,1/78*

MISCELLANEOUS

GET WARM THIS WINTER ON Grand Cayman in British West Indies. Comfortable two-bedroom plus sleeping porch on beach overlooking sea and surf. Everything furnished. (Not available, 12-16-77 to 1-20-78). $200 week. Write Box 44, Boddentown, Grand Cayman, BWI. 12/77,1/78 ■

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

A Time To Be Born. By David Bell, MD. Dell Publishing Co, Inc, 1 Dag Hammarskjold Plaza, 245 East 47 St, New York, NY 10017. 1977. Pp 189. Price: $1.95.

Child Care Issues for Parents and Society: A Guide to Information Sources. By Andrew Garoogian; Rhoda Garoogian and Gloria Weinberger. Gale Research Co, Book Tower, Detroit, Mich 48226. 1977. Pp 367. Price: $18.00.

Handbook of Poisoning: Diagnosis Treatment. By Robert H Dreisbach, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1977. Pp 559. Price: $8.00.

Handbook of Pediatrics. By Henry K Silver, MD; C Henry Kempe, MD; and Henry B Bruyn, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1977. Pp 723. Price: $9.00.

Blood Policy: Issues and Alternatives. Edited by David B Johnson. American Enterprise Institute for Public Policy Research, 1150 17th St, NW, Washington, DC 20036. 1977. Pp 212. Price: $4.75.

The Nervous System. By William F Ganong, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1977. Pp 226. Price: $8.00.

Nothing To Fear Coping With Phobias. By Fraser Kent. Doubleday and Company, Inc, 245 Park Ave, New York, NY 10017. 1977. Pp 204. Price: $7.95.

Plagues and Peoples. By William H McNeill. Doubleday and Company, Inc, 245 Park Ave, New York, NY 10017. 1977. Pp 340. Price: $3.50.

For the Love of Children. By Edward E Ford and Steven Englund. Doubleday and Co, Inc, 245 Park Ave, New York, NY 10017. 1977. Pp 152. Price: $6.95.

Crossroads—Health Care For Rural Wisconsin. Prepared by Lora Collins; Douglas N Mormann; Randall A Neff; William G Wendle. Charitable, Educational and Scientific Foundation, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701. Pp 64. Price: In-state, 5 free copies, each additional copy $1.00; Outside state, $1.00 per copy. ■

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing; 25¢ per word, with a minimum charge of $10.00 per listing for succeeding insertions of the same listing up to one year.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch for first insertion; $12.00 per column inch for succeeding insertions of same listing up to one year.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

Medical College of Wisconsin

Winter Refresher Course for Family Physicians

Thurs-Fri-Sat/Jan 19-20-21, 1978
Pfister Hotel & Tower/Milwaukee

Two and one-half days. AMA Physician's Recognition Award, 16-18 credit hours. AAFP, 16-18 credit hours.

Course director: Thomas F Garland, MD, Associate Professor of Family Practice, and Program Director, Family Practice Residency Program, Deaconess Hospital.

Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians.

* * *

Further details: Dept of Family Practice, MCW, 610 North 19th St, Milwaukee, Wis 53233.

1978 WISCONSIN

Jan 19: *In-Depth Teaching Program*, St Marys Hospital Medical Center, Madison.

Jan 19-21: *Winter Refresher Course for Family Physicians*. Sponsored by Dept of Family Practice, Medical College of Wisconsin, and Southeastern Chapter of Wisconsin Academy of Family Physicians. Pfister Hotel and Tower, Milwaukee.

Jan 28-29: St Mary's Hospital International Burn Symposium, Milwaukee. See details elsewhere in this section.

Feb 1-4: *A Comprehensive Approach to Endoscopy*, Medical College of Wisconsin, Milwaukee. Details elsewhere in this issue.

Feb 3: *Cleaning, Disinfection and Maintenance of Endoscopes*, Medical College of Wisconsin, Milwaukee. Details elsewhere in this issue.

Feb 14-16: *Fifteenth Annual Telemark Symposium and Ski Outing*. Sponsored by the Indianhead Chapter of the Wisconsin Academy of Family Physicians at Mount Telemark, Cable, Wis. Six hours of CME credit, and AAFP prescribed credit. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

Feb 15: *In-Depth Teaching Program*, Methodist Hospital, Madison.

Mar 1-Apr 5: *Recent Advances in Internal Medicine for the Practicing Clinician; Series 6: Infectious Disease*, Medical College of Wisconsin, Milwaukee.

41st Annual
New Orleans Graduate Medical Assembly

March 31 - April 4, 1978

Meeting Theme:
The High Risk Patient

Accreditation:
AMA-Category I/AAFP, ACEP

Program Director:
Oliver H Dabazies Jr, MD FACS

Fee: $200 nonmember physicians. Military: $100. Students, residents, interns and fellows: complimentary registration.

Write or phone:
New Orleans Graduate Medical Assembly, Room 1538 Tulane Medical Center, 1430 Tulane Ave, New Orleans, La 70112; 504/525-9930. 11-12/77, 1-2/78

Mar 16: *In-Depth Teaching Program*, UW Center for Health Sciences, Madison.

Mar 29-Apr 5: *Gynecological Pathology, Cytogenetics, Endocrinology*, Medical College of Wisconsin, Milwaukee.

Mar 30-Apr 1: Second Annual *Ophthalmology Current Concepts Seminar '78* of the University of Wisconsin-Madison. Lectures and workshops. Sponsored by the Dept of Ophthalmology Faculty, University Hospitals, Madison; at The Wisconsin Center, Madison. Info: Mrs Margaret Kelm, UW Hospitals, 1300 University Ave, Madison, Wis 53706.

Apr 1: Southeastern Wisconsin Cancer Conference (tenth annual), at Pfister Hotel, Milwaukee. Topic: *Colon Cancer*. Frank E Berridge, MD, Conference Chairman, ph 414/463-1220.

Apr 6-27: *Diabetes* lectures around the state.

Apr 13-15: SMS Annual Meeting, MECCA, Milwaukee. Headquarters Hotel: Marc Plaza.

Apr 28: *Pediatric Anesthesia*, LaCrosse.

May: Spring Meeting, Wisconsin Neurological Society.

May 12: *Perinatal Medicine*, LaCrosse.

CLEANING, DISINFECTION AND MAINTENANCE OF ENDOSCOPES

GI Assistants course sponsored by the Section of Gastroenterology The Medical College of Wisconsin

February 3, 1978, Milwaukee, Wis

This seminar will deal with the prevalence and prevention of infectious diseases in the endoscopy unit, cleaning and basic maintenance of endoscopes and endoscopic equipment.

Participating in the presentations and discussions will be a microbacteriologist, an epidemiologist, endoscopy nurses and representatives of instrument and pharmaceutical companies.

This course is being held in conjunction with the 6th Annual Endoscopy Conference for Physicians, sponsored by the Medical College of Wisconsin, February 1-4, 1978.

Registration fee: $75

Info: Ms Marcis Pfeifer, RN, Course Director, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406

May 11-13: *Heart Disease and Rehabilitation: State of the Art 1978* at Marc Plaza Hotel, Milwaukee. Sponsored by Cardiovascular Disease Section of Mt Sinai Medical Center, Wisconsin Heart Association and University of Wisconsin, Milwaukee. Info: Carl Foster, PhD, Dept of Medicine, Cardiovascular Disease Section, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee, Wis 53201.

May 19-20: *Emergency Problems in Pediatrics,* UW-Madison.

June 23-25: *Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians* at The Hilton Hotel, Eau Claire, Wis. Ten hours of CME and AAFP prescribed credit. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

1978 NEIGHBORING

May 14-16: *Perinatal Care from Community to Center,* Eighth Annual Meeting of the Great Plains Organization for Perinatal Health Care, Radisson South Hotel, Bloomington, Minn. Info: Mrs. Virginia Rittenour, Coordinator, Great Plains Organization, 420 Delaware St, SE, Box 50, Minneapolis, Minn 55455. Phone: 612/373-5718. gl2tfn/77

Feb 21-23: CME Course: *Approaches to Clinical Problems in Gastroenterology and Hepatology,* sponsored by University of Chicago Section of Gastroenterology and Liver Study Unit. At Center for Continuing Education, Chicago. Approved for 22 hours of Category I credit for AMA-PRA. Info: Sumner C Kraft, MD, Course Director, 950 E 59th St, Chicago, Ill 60637. 12/77, 1/78

Feb 25: *Conference on Colon-Rectal Cancer,* Red Wing Area Technical Institute, Red Wing, Minn. Info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

1978 OTHERS

Jan 12-14: Colorado Regional Meeting of American College of Physicians in Colorado Springs. Physicians attending are eligible for credit toward AMA-PRA in Category I.

Conference on Colon-Rectal Cancer

Red Wing Area Technical Institute, *Red Wing, Minn*

Saturday, Feb, 25, 1978

Program from 9 am to 3:45 pm

- *Introduction and Overview of Critical Management Issues,* Hugh L Davis, MD, UW-Madison Center for Health Sciences, Madison, Wis
- *Early Diagnosis — Our Best Weapon Screening Physical Examination Endoscopy, CEA,* James E VanderMeer, MD, Dean Clinic, Madison, Wis
- *Roentgen Diagnosis of Colon-Rectal Lesions,* Harley C Carlson, MD, Mayo Clinic, Rochester, Minn
- *Surgical Therapy of Colon-Rectal Cancer,* Theodore B Grage, MD, University of Minnesota
- *Panel,* above participants
- *The Role of Radiation Therapy,* Robert H Greenlaw, MD, Marshfield Clinic, Marshfield, Wis
- *Combined Modality Treatment: Adjuvant Therapy—The Medical Oncologist's View,* Hugh L Davis, MD
- *Combined Modality Treatment: A Surgeon's View of Adjuvant Therapy,* Theodore B Grage, MD
- *Paliative Management of Advanced Disease,* Hugh L Davis, MD
- *Panel,* all participants

Further info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

Winnebago Mental Health Institute, Winnebago, Wis

January-May CME Programs

***Jan 13:** "Psychiatric Emergencies and Nursing Care,"—Ms Cynthia A Dwelle, RN, Director of Crisis Center Detroit General Hospital.

Registration:	9:45 - 10:15
Part I	10:30 - 12:00
Part II	1:15 - 3:00

*Acceptable for 4 credit hours, Category I, AMA-PRA

***Jan 20:** "Sexual Issues and the Treatment of Women,"—Ann Shannon, ACSW, Assistant Director, Social Work Supervisor of the Outpatient Psychiatric Clinic of Loyola University Hospitals.

Part I	10:30 - 12:00
Part II	1:15 - 3:00

*Acceptable for 4 credit hours, Category I, AMA-PRA

***Feb 22:** "Recent Advances in Psychopharmacology,"—John M Davis, MD, Director of Research, Illinois State Psychiatric Institute and Professor of Psychiatry, Chairman of Chicago Medical School.

Part I	10:30 - 12:00
Part II	1:15 - 3:00

*Acceptable for 4 credit hours, Category I, AMA-PRA

***Mar 9:** "Recent Developments in Current Concepts of Geriatric Psychiatry," Murray Raskin, MD, Department of Psychiatry, University of Washington.

Registration:	9:15 - 9:45
Part I	10:00 - 12:00
Part II	1:15 - 3:00

*Acceptable for 4 credit hours, Category I, AMA-PRA

Mar 17: "Teaching Children with Behavior and Communication Problems,"—Dr Donald Hamill, PhD, Professor, Department of Speech, University of Texas.

Registration:	8:30 - 9:15
Part I	9:30 - 12:00
Part II	1:15 - 3:00

Apr 28: "Systematic Human Relationship Training,"—Ms Marilyn LaCourt and Dr Ralph Van Atta, PhD, Director of the Human Laboratories, Wauwatosa.

Part I	10:00 - 12:00
Part II	1:15 - 3:30

***May 26:** "Recent Developments and Current Concepts in Depression,"—Dr Remi J Cadoret, Professor Psychiatry, Department of Psychiatry, University of Iowa School of Medicine.

Registration:	9:45 - 10:15
Part I	10:30 - 12:00
Part II	1:15 - 3:00

*Acceptable for 4 credit hours, Category I, AMA-PRA

Info: Steve Kearney, Dir of Educational Services, Winnebago Mental Health Institute, Box H, Winnebago, Wis 54985. Phone 414/235-4910, ext 316.

METHODS OF BURN TREATMENT

Second International Burn Symposium of St Mary's Hospital, Milwaukee

January 28-29, 1978

Co-chairmen: Burton A Waisbren, MD, Director of the Burn Research and Clinical Paradigm Laboratory and Associate Director of the Burn Center; and George E Collentine, Jr, MD, Director of St Mary's Burn Center.

Proof of Efficacy of Methods of Burn Treatment—Alternate Pathways will be the subject of the two-day session in which the foremost international burn surgeons will be allowed to present a specific method of burn treatment to an expert panel of critiquers, who will analyze the results. The audience will also be allowed to critique the presentations.

Presenters:

—**William F Monafo, MD,** Dept of Surgery, St John's Mercy Medical Center, St Louis, Mo.

—**Burton A Waisbren, MD,** St Mary's Burn Center.

—**George B Hart, MD,** Long Beach Hyperbaric Center, Long Beach, Calif.

—**John F Burke, MD,** Shriners Burns Institute, Boston, Mass.

—**Bent Sorensen, MD,** Professor of Surgery, University of Copenhagen, Denmark.

—**J Wesley Alexander, MD,** Shriners Burns Institute, Cincinnati, Ohio.

—**Irving Feller, MD,** University of Michigan Burn Center, Ann Arbor.

The first St Mary's Symposium dealt with the issue of skin banking. The objective of this session is to help those engaged in the treatment of burns to decide whether there is enough evidence for them to justify the use of the new modalities being discussed. Furthermore, the intimate exposure with the foremost experts on experimental design in this country will allow them to more scientifically evaluate and present new methods of treatment that they may develop.

For additional information contact Peter Hanson or Mary Sparks, 414/289-7144 at St Mary's Hospital, Community Relations Department, Milwaukee, 2323 North Lake Drive, PO Box 503, Milwaukee, Wis 53201.

NATIONAL MEDICAL SPECIALTY SOCIETIES

1978 Meeting Dates/Sites

Apr 24-26: American Academy of Neurology, Los Angeles.

Apr 23-27: American Association of Neurological Surgeons, New Orleans.

Sep 25-28: Annual Scientific Assembly, American Academy of Family Physicians, San Francisco.

Oct 16-20: Clinical Congress, American College of Surgeons, San Francisco.

Mar 13-16: Spring Meeting, American College of Surgeons, Cincinnati.

University of Wisconsin-Madison

Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

CME Calendar—1978

Jan. 10: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Feb. 8: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Feb 14: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Mar 14: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Apr 11: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Apr 11-12: *Patient Education,* The Concourse Hotel, Madison.

Apr 13-15: *Seminar-Workshop in Radiology,* The Wisconsin Center, Madison.

Apr 21-22: *Conference on Dermatology,* The Wisconsin Center, Madison.

Info: Coordinator, Dept of CME, 601 Walnut Street, Madison, Wis 53706; phone: 608/263-2850.

Jan 28-29: Second International Glaucoma Congress, at Americana Hotel in Miami Beach, Fla. Being held in conjunction with Annual Scientific Assembly of American Society of Contemporary Ophthalmology, Jan 30-Feb 3. Info: Dr John Bellows, Director, 6 North Michigan Ave, Chicago, Ill 60602. g8-12/77

Jan 30-Feb 3: Annual Scientific Assembly of American Society of Contemporary Medicine and Surgery, at Americana Hotel in Miami Beach, Fla. Meets criteria for 40 hours of credit in Category I for AMA-PRA. Info: John G Bellows, MD, PhD, Director, 6 North Michigan Ave, Chicago, Ill 60602; (312) 236-4673. g8-12/77

Mar 29-31: *Diagnostic and Therapeutic Advances in Gastroenterology,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Oct 17-21: *Medical Knowledge Self-Assessment Program Course,* Hyatt Regency, New Orleans, La. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa 19104.

University of Wisconsin Medical School-Madison

Department of Ophthalmology Faculty

2nd Annual

OPHTHALMOLOGY CURRENT CONCEPTS SEMINAR "78"

March 30 - April 1, 1978
Wisconsin Center, 702 Langdon St, Madison

Participating Faculty

Richard Appen, MD
George Bresnick, MD
Frederick Brightbill, MD
Suresh Chandra, MD
Matthew Davis, MD
Guillermo de Venecia, MD
Richard Dortzbach, MD
Terry Ernest, MD
Thomas France, MD
Paul Kaufman, MD
Burton Kushner, MD
Frank Myers, MD
Harry Roth, MD
Thomas Stevens, MD
Rodney Sturm, MD
Ingolf Wallow, MD

Info: Mrs Margaret Kelm, University Hospitals, 1300 University Ave, Madison, WI 53706

1978 AMA

June 17-22: American Medical Association Annual Meeting, St Louis.

Dec 2-6: AMA House of Delegates Interim Meeting, Chicago.

Dec 7-10: AMA Winter Scientific Meeting, Las Vegas.

1978 Madison
In-Depth Teaching Programs

Preliminary Schedule

Jan 19, 1978—(Thursday) St Marys Hospital Medical Center

Feb 15, 1978—(Wednesday) Methodist Hospital

Mar 16, 1978—(Thursday) University Hospitals—(changed from Nov 17, 1977)

A COMPREHENSIVE APPROACH TO ENDOSCOPY

6th Annual Endoscopy Conference

Sponsored by Section of Gastroenterology, The Medical College of Wisconsin

February 1-4, 1978, Milwaukee

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The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for October 1977.

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RUBELLA BROCHURES STILL AVAILABLE

Another reminder: It's not too late to order the SMS brochure on Rubella and Red Measles Immunization. The 2½ by 4 inch sized brochure is perfect for placement in patient waiting rooms or for inclusion in billing statements.

PHYSICIANS: ARE YOUR MEDICAID CLAIM FORMS COMPLETE?

Physicians are reminded to make sure that all necessary information is included on the Medicaid claim forms they submit to carriers for payment. The following information is essential for BOTH assigned (provider submitted) and non-assigned (patient submitted) claims: exact date for each service; place of service; brief description of surgical or medical procedure; diagnosis of symptom; and separate charge for each service.

DHSS PROPOSES RULES ON LABORATORY FEES

The 1977-79 state budget bill revised the Wisconsin laboratory certification program to permit the Department of Health and Social Services to increase laboratory certification fees. SMS was successful in amending the budget bill to require that the fees be based not only upon the number of "specialties" a lab tests for, but also the volume of the tests performed in each category. Former Governor Lucey vetoed the "volume" language which was inserted in the bill, with the result being fees based solely upon the number of testing categories.

The DHSS conducted a public hearing in November on its proposed fee structure and received adverse comments from all citizens present at the hearing. As proposed by the Department, the fee structure would range from $75 for a single specialty testing category to $1,200 for six specialties. Inasmuch as all state hospitals and institutions would be exempt from the fees, the charges applied to private physician and hospital labs would have to generate the revenue to totally finance the program. Annual costs for the state-run certification program are approaching $590,000.

Department officials present at the November hearing stated that the final rule and fee structure would be forwarded to DHSS Secretary Donald Percy in a matter of days. SMS will petition the legislative committees responsible for reviewing the rules for another public hearing. Because former Governor Lucey chose to veto the SMS language, legislative review is considered to be crucial to any future revision of the rule.

RESIDENT PHYSICIANS SECTION PUBLISHES NEWSLETTER

November marks the first issue of a new publication by the State Medical Society called the "Wisconsin Housestaff Forum." The newsletter will be sent to Wisconsin resident physicians informing them of the progress of the newly organized Wisconsin Resident Physicians Section within the State Medical Society. The editor of the newsletter is Stephen Imbeau, MD of Madison.

AMA ANNOUNCES AD CAMPAIGN

The American Medical Association recently announced its plans to launch an advertising campaign in selected national publications emphasizing the positive aspects of American medicine today. James Sammons, MD, executive vice-president of the AMA, said the campaign is tentatively scheduled to begin in March 1978. "Our campaign will be informational and factual and will emphasize the positive aspects of US medicine today," Doctor Sammons said. "It will remind people of the good news that is often overlooked in the dialogue on future health policy—the tremendous growth in the US medical system in the last decade, the improvements in national health statistics, growing accessibility of care. It also will explain why costs have risen, suggest possible remedies,, and identify risks inherent in NHI proposals that would radically restructure the system." ■

Pulmonary Contusion —A Problem in Blunt Chest Trauma

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George M Kroncke, MD
Herbert A Berkoff, MD
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Madison, Wisconsin

● **Pulmonary contusion is recognized more and more frequently following blunt chest trauma. Prompt recognition and rapid institution of supportive therapy is the key to successful management. In the patients who sustain the severest injury, prolonged respiratory support with an extracorporeal membrane oxygenator is warranted.**

PULMONARY CONTUSION is now more frequently recognized in blunt chest injuries resulting from traffic accidents and plays a major role in approximately 25% of these deaths.[1,2] Basically, pulmonary contusion is damage to the lung parenchyma. The presence of a high pressure wave compresses the lung while compressing the chest wall and this sudden pressure results in pulmonary parenchymal hemorrhage and edema.[3] Associated rib fractures actually serve as a protective mechanism by interrupting the force of trauma before the severe chest compression occurs. In various series, the incidence of pulmonary contusion in blunt chest trauma varies between 30% and 75%. Pulmonary contusion is frequently mild and is overshadowed by more severe injuries such as hemopneumothorax or flail chest; however, it may be severe and cause death in itself.

The pathological findings in pulmonary contusion result primarily from alveolar capillary damage with interstitial edema and intraalveolar and interstitial extravasation of blood. The severity of the initial injury often determines the degree of parenchymal damage and extent of involvement. When parenchymal damage is minimal, there are focal areas of interstitial edema and minimum intraalveolar hemorrhage.[4,5] There is little alteration in pulmonary function when the degree of trauma is mild.

Microscopically, rupture of the alveolar walls and alveolar hemorrhage occurs when the alveolar and interstitial spaces show transudation of edema fluid. Often hemorrhage does not occur in the alveoli, particularly when the larger pulmonary vessels are injured, but dissects along the interstitial planes around the vessels and bronchi.

When the injury is severe, damage to the lungs is widespread and the classical "wet lung" (heavy, edematous, and consolidated) is seen at autopsy. A vicious cycle is set up causing atelectasis with the accumulation of blood, tissue fluid, and cellular debris obstructing the smaller air passages and the alveoli.

Mucous production is increased due to trauma and the patient is unable to cough mucoid secretions because of the pain resulting from chest wall injury. The atelectatic areas of lung parenchyma no longer serve as units of effective gas exchange and this leads to an alteration in the ventilation perfusion ratio and, ultimately, to tissue hypoxia. There is reflex tachypnea and tachycardia. Air flow resistance in the tracheobronchial tree is increased. Pulmonary compliance is diminished and the work of breathing greatly increases and an oxygen deficit occurs due to inability to meet the increased demand resulting from the increased work of breathing. This cycle ultimately leads to hypoxia and respiratory acidosis. Ultimately, systemic hypoxia supervenes and leads to myocardial depression.

In 15% to 20% of these patients, myocardial depression also results directly from the blunt chest trauma, thus further aggravating the clinical situation.[2] Cardiac output falls and metabolic acidosis results. If the severity of initial trauma results in loss of major areas of lung parenchyma as effective units of gas exchange, death ultimately occurs from persistent severe hypoxia.

The radiological picture also varies widely in appearance and dis-

From the Division of Thoracic and Cardiovascular Surgery, University of Wisconsin-Madison Medical Center, Madison.
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tribution. This variation depends upon the degree of severity of pulmonary contusion resulting from the initial trauma. An important feature is that the roentgenographic findings in pulmonary contusion appear quite abruptly and, likewise, clear quite rapidly.

There may be no evidence of any pulmonary injury on the initial roentgenographic examination. This baseline information is important for future comparison. There are two usual types of roentgenographic findings. The more common one is a patchy pulmonary infiltrate with ill-defined areas of pulmonary density resulting from intraalveolar hemorrhage. The extent of involvement is either very localized or can show an extensive homogeneous opacification.

Less frequently, one sees linear, irregular, peribronchial infiltrates from peribronchiolar hemorrhage. An improvement in the roentgenographic appearance begins to occur in 48 to 72 hours following initial trauma and it may be as long as two weeks before complete resolution occurs. This pattern is so typical that some other complicating factor should be suspected if resolution does not occur after about 72 hours.

The clinical pattern and treatment of pulmonary contusion depend upon the severity of the trauma. Very often, clinical symptoms are delayed regardless of the severity of injury or the absence of radiological findings. However, based on the clinical findings, patients can be divided into three groups.

Group A:

Patients in this group can be asymptomatic or have minimum symptoms. There is definite roentgenographic evidence of pulmonary contusion; patients have chest pain but are able to cough and clear secretions effectively; tachycardia and tachypnea are present and scattered rales are heard on auscultation; a loose cough with blood tinged secretions is occasionally present; and arterial blood gas studies show a mild decrease in the pO_2 with a minimal elevation of pCO_2. The roentgenographic appearance of the contusion is often much more impressive than the clinical condition of the patient. The clinical course of this group of patients is characterized by a gradual and steady disappearance of all symptoms and rapid resolution of pulmonary parenchymal changes and arterial blood gases return to normal. If clinical deterioration occurs in this group, and roentgenographic findings indicate an extension of the lesion, complicating factors such as pneumonitis, fat emboli, or pulmonary emboli should be suspected.

Meticulous tracheobronchial care, including nasotracheal suctioning and chest physiotherapy, are the key factors in successful management of these patients. Occasionally, when excessive mucoid secretions cannot be cleared by these means, bronchoscopy is necessary. Other supportive measures include adequate humidification of inspired air by ultrasonic nebulization and intermittent positive pressure breathing. Ventilation is helpful in mobilizing the removal of inspissated mucoid secretions; nasal oxygen may be required for a day or two; and judicious use of narcotics and intercostal nerve blocks are used to alleviate pain. Cultures of tracheobronchial secretion are routinely obtained and all patients are given a broad spectrum antibiotic because of the danger of severe infection in an already damaged pulmonary parenchyma. With the institution of the above measures, survival in this group approaches 100 percent.

Group B:

Patients in this group have more severe injury. Associated multiple injuries of other organ systems can initially detract attention from the underlying pulmonary injury and delay the diagnosis until after the lung has been reexpanded with the evacuation of the blood and air from the pleural space.

Clinically, these patients are restless, apprehensive, and their respirations are rapid and labored. There is tachycardia and one can hear "wet" rales on auscultation. The restlessness and apprehension which are early signs of hypoxia are often mistakenly attributed to pain or cerebral injury.

The chest roentgenogram shows a characteristic pattern of severe pulmonary contusion and there are ill-defined areas of homogeneous opacification. Changes in the arterial blood gases often precede the development of the typical clinical picture. The pO_2 and the pH are moderately decreased; the pCO_2 is elevated; there is an increase in the alveolar arterial oxygen gradient (Aa-DO2); and the patient has a continuous wet cough from copious amounts of thick mucoid sputum and occasional bloody secretions which he is unable to effectively clear.

The dyspnea and tachypnea increase with progressive respiratory insufficiency. There is corresponding deterioration of arterial blood gases; the pO_2 and pH show a progressive decline; and the alveolar arterial oxygen tension further widens. Associated hypovolemic shock and myocardial contusion further complicate the situation.

It is vitally important to suspect the presence of a severe pulmonary contusion in any patient who has had severe chest trauma because survival depends on early diagnosis and vigorous treatment. Arterial blood gas analysis done upon admission aids in early recognition of hypoxia and its immediate treatment.[6] The primary aim here is the prevention of systemic hypoxia by restoration and maintenance of adequate oxygenation. This is best done by endotracheal intubation and mechanical ventilation with a volume-cycled respirator. Humidification of inspired oxygen helps considerably. Because of the potential threat of oxygen toxicity, the lowest possible concentration of inspired oxygenation should be used so that one can maintain the pO_2 in the physiological range.[7] In order to assess the patient's progress with the therapy, arterial blood gas analyses are determined at regular intervals; aseptic endo-

tracheal suction is done frequently; secretions are sent for cultures; and antibiotic therapy is modified as necessary. Gastric dilatation and the danger of aspiration are prevented by keeping the stomach decompressed with a nasogastric tube.

Skillman and associates have shown the effectiveness of the combined use of diuretics and salt poor albumin in patients with respiratory failure.[8] Furosemide (Lasix®), 40 mg, and salt poor albumin, 25 mg, are given daily, carefully monitoring serum electrolytes. Steroids in large dosages, 30 mg/kg of methylprednisolone sodium succinate (Solumedrol®), also help in the reduction of secretions and interstitial pulmonary edema.

In spite of all the above measures, there is about 15% mortality with moderately severe pulmonary contusion. Most of these deaths occur in the first week following injury. In the majority of survivals, the pulmonary pathological changes clear in about two weeks from the onset of injury, chest roentgenograms also return to normal, and there is little functional impairment of the lungs.

Group C:

In this group of patients, the injury is very severe with almost complete, dense opacification of both lung fields on initial chest roentgenograms. Respiratory failure occurs early, manifested by tachypnea, tachycardia and cyanosis; systemic hypoxemia is manifested by extreme agitation and restlessness; incessant coughing brings up frothy mucoid, often bloody, secretions; scattered bronchial breath sounds with wheezes and rales are heard on auscultation; the arterial pO_2 and pH are markedly decreased with a parallel rise in the pCO_2 level, and the alveolar arterial oxygen gradient is widened.

In spite of the prompt and early institution of all the various measures outlined in the management of the previous group of patients (ventilatory support, with high concentration of O_2 as necessary, judicious control of fluid management, steroids, and the like), the mortality remains very high, and most of the patients die from systemic hypoxia within three to four days following injury.

Recently, there has been some hope for salvaging these individuals. Prolonged ventilatory support leading to recovery has been possible in some patients. Recent reports by Hill,[9,10] Pierce,[11] and Kolobow[12] demonstrate that with the use of a membrane oxygenator some of the problems of prolonged extracorporeal pulmonary support have been markedly reduced. There is much less red cell damage and denaturation of protein surfaces; and this, in turn, has led to fewer clinical problems associated with clotting mechanisms following prolonged extracorporeal bypass. Kolobow[12] reported a case in which prolonged extracorporeal respirator support, for ten days, with a membrane lung was successfully accomplished. Hopefully, in the near future, by utilizing such techniques, more cases of severe pulmonary injury can be salvaged.[13]

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ABSTRACTS WISCONSIN AUTHORS

Factors Predictive of Perioperative Myocardial Infarction During Coronary Operations

ROBERT J FLEMMA, MD; HARJEET M SINGH, MD; ALFRED J TECTOR, MD; DERWARD LEPLEY JR, MD; and ROGER P GABRIEL, PA, Milwaukee, Wis: *Ann Thorac Surg* 21:215-220 (Mar) 1976

The diagnosis of perioperative myocardial infarction(PMI) in our patients was based upon electrocardiography, vectorcardiography, and postoperative enzyme changes. A group of 303 patients operated on between January and September 1972, formed the basis of this study. Three groups were identified from among these patients. Group A was composed of 90 consecutive patients in whom MI was excluded by all criteria. Group B comprised 25 patients with proved MI and yielded the 8% incidence of MI among our patients. Group C included 34 patients with triple-vessel disease who did not sustain MI.

Significantly more patients sustaining MI had preinfarction angina and severe coronary artery disease. The incidence of MI was also higher in patients with diffuse disease and those in whom the lesions could not be totally bypassed. A statistical correlation with longer pump runs and periods of anoxia was obtained. There was some suggestion that the preoperative location of the hypokinetic segment determined the site of MI in these patients. ■

Serum Enzymes in Peroneal Muscular Atrophy

(Charcot-Marie-Tooth Disease)

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PERONEAL MUSCULAR atrophy (Charcot-Marie-Tooth disease) is a heredofamilial neurologic disorder usually transmitted as an autosomal dominant form, but it can appear as an autosomal recessive.[1] It is more often manifested in childhood or adolescence, but it can appear later in life; the prevalence rate appears to be between 2 and 5 per 100,000.[2]

The clinical signs are pes cavus and muscle wasting, which begins in the anterior muscles of the lower leg, followed by muscle degeneration of the calf muscles and distal portions of the thigh. Later, the intrinsic muscles of the hand can become atrophied.[3]

This study on serum enzymes was part of an investigation of blood with the hope of finding an alteration that may be suggestive of an error of metabolism related to the cause of the disorder. The sera of patients were examined qualitatively and quantitatively for enzymes important to muscle metabolism and known to show abnormalities in other neuromuscular and related disorders. If an enzyme was found to be significantly altered, it could, in turn, be used as a diagnostic tool. All the patients, except one, were inhabitants of Wisconsin.

Methods

Fourteen patients with Charcot-Marie-Tooth (CMT) disease were studied. Nine were males between the ages of 12 and 57 years (six were brothers from three families). The five females were between the ages of 8 and 42 years (none were sisters). The duration of the condition for the 14 patients was from 1 to 33 years. All the CMT patients were ambulatory.

Fasting blood was drawn and the cell-free unhemolyzed serum divided into small volumes, one for each enzyme and rapidly frozen if the enzyme estimations were not performed immediately. Heparinized blood was used for the transketolase analysis. Control specimens of fasting blood also were drawn from persons who were not hospital patients and who had no neurological problems.

The serum enzymes investigated quantitatively using Sigma* kits were as follows: aldolase, phosphohexose isomerase, lactate dehydrogenase, glutamate-oxaloacetate transaminase, glutamate-pyruvate transaminase, isocitrate dehydrogenase, alkaline phosphatase, 5′-nucleotidase, arylamidase, α-hydroxybutyrate dehydrogenase, esterase, creatine phosphokinase, and lipase.

The transketolase content of heparinized blood and the effect of thiamine pyrophosphate addition *in vitro* was performed according to the method of Schouten.[4]

In the qualitative study of the serum enzymes the banding patterns of the isoenzymes were examined by polyacrylamide gel electrophoresis. The polyacrylamide gels were 7% grade buffered to pH 8.9 and a current of 1.5 mA/gel was applied for approximately 2.5 hours at 3-5°C. Visual examination of the isoenzymes was achieved by incubating the gels in the appropriate substrate medium according to the methods of Brewer.[5]

Results

The findings of the quantitative serum enzyme analysis are given in Table 1. The normal enzyme range is in parenthesis followed by the appropriate unit for the technique used. There was no one single enzyme that showed a significant abnormality, but a few interesting features did appear.

Aldolase activity was raised in seven cases but only in three cases were the levels significantly elevated. The lactate dehydrogenase activity was raised in seven cases but only one had an abnormally high level. Glutamate-oxaloacetate transaminase levels were altered in four cases. Creatine phosphokinase activity appeared in a borderline range for three cases. Other enzyme activities did not show marked variations from accepted normal ranges.

The CMT serum isoenzyme banding patterns obtained with polyacrylamide electrophoresis were normal for malate dehydrogenase. The lactate dehydrogenase patterns were abnormal for one patient who had a less dense LD_1 band. The esterase banding pattern was abnormal for three in which an extra band appeared between the 4th and 5th band. The extra band was not intense but it was distinct. The serum alkaline phosphatase isoenzyme pattern showed one distinct band for controls but in two of the CMT patients, three moderately stained bands were observed.

Discussion

The objective of this study was to determine whether an enzyme abnormality was present in the blood of sufferers with Charcot-Marie-Tooth's disorder suggestive of a defect related to the cause of

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*Reagents for all the enzyme analysis except transketolase were obtained from the Sigma Chemical Co, St Louis, Mo 63178 in kit form. The incubation temperatures and time intervals used in this study were those suggested by the Sigma Chemical Co.

the condition. The raised levels of aldolase, lactate dehydrogenase, glutamate-oxaloacetate transaminase and creatine phosphokinase which were observed in some CMT patient's sera were probably due to the release of these enzymes into the circulation resulting from the breakdown of muscle cell membranes and were not thought to be a factor in the cause of this disorder.

If an enzyme were to be directly related to the cause of CMT one would expect to find the specific enzyme at an abnormal level in a large percentage of the patients whose cases were examined. Only 50% or less of the CMT patients' blood sera had elevated levels for the four enzymes mentioned above.

Transketolase requires thiamine pyrophosphate (TPP) and Mg^{2+} as cofactors in order to transfer a ketol group from xylulose-5-phosphate to ribose-5-phosphate to form sedoheptulose-7-phosphate and glyceraldehyde-3-phosphate.[6] The activity of transketolase is depressed when there is a thiamine deficiency. Whole blood from the CMT patients was analyzed for transketolase content and the effect of thiamine pyrophosphate addition *in vitro* (TPP effect) was determined. If the CMT patients have a thiamine deficiency, the addition of thiamine pyrophosphate to the whole blood would increase the activity of transketolase. The possibility of thiamine deficiency was considered since the central nervous system relies heavily upon carbohydrate metabolism for energy and in thiamine deficiency the utilization of glucose by the central nervous system may be decreased as much as 50 to 60 percent.[7] Furthermore, it has been stated that thiamine deficiency can cause degeneration of myelin sheaths of nerve fibers both in the peripheral nerves and in the central nervous system.[7] Such deficiencies would decrease the ability of the central nervous system to function. Transketolase activity was slightly elevated in the blood of only two CMT patients. Since the addition of TPP (Vitamin B_1) did not increase the level of transketolase activity, there was no evidence of thiamine deficiency in the CMT patients.

Table 1—Levels of selected enzymes in sera of CMT patients

PT	SEX	AGE	DURATION OF CONDITION (YEARS)	ALDOLASE (3-8) SIBLEY AND LEHNINGER	PHI (8-40) BODANSKY	LDH (100-350) BERGER AND BROIDA	SGOT (0-28) FRANKEL	SGPT (0-35) FRANKEL	ICD (50-180) SIGMA	ALK. PHOSPHATASE (0.8-3.0) SIGMA	5-NUCLEOTIDASE (0-.68) SHINOWARA	ARYLAMIDASE (75-220) GOLDBERG & RUTENBERG	α-HBD (19-72) SIGMA	ESTERASE (48-158) RAPPAPORT	CPK (0-12) SIGMA	LIPASE (0-1) TIETZ	TRANSKETOLASE (60.6-73.6) INT. UNITS	TPP EFFECT (0-8.7) PERCENT
			NORMAL RANGE UNITS															
1	M	39	24	7.5	20	280	19	24	80	3.7*	.33	180	28	94	9	.20		
2	M	46	30	10.5*	25	333	33*	17	55	3	0	180	45	110	7	.38		
3	F	42	15	2.5	10	280	17	9	70		.09	100	21.3	67	2	.30		
4	F	36	33	3.3	18	310	15	7.5	65	1.2	.09	113	51	61	4	.37	70	0
5	F	40	28	6.5	11	195	23	13.6		2.1			44	115	4		72.8	0
6	M	49	4	10 *	28.5	330	20	17	113	2.2	.02		53	77	4	.42	74.4*	2.8
7	M	53	3	14.3*	25	405*	35.5*	21.6			.47		45	125		.43	76.2*	0
8	M	57	25	9.8*	18	472*	20	11.5	95	1.7	.02	135	65	88	16*	.63	71.8	1.4
9	M	27	10	13.5*	16.3	255	21.5	10			0		20	79		.48		
10	M	22	4	14.5*	24	385*	36.5*	12.5			0		65	97		.44	73.6	2.7
11	F	8	7	11.3*		385*	30 *		87	6.2			86*		9			
12	M	51	20			560*			120	1.7		135		113	20*			
13	M	12	1			392*			65	4		173			13*			
14	F	16	2			360*			95	2.5		163			7			

* Borderline or elevated levels

The serum isoenzyme pattern was analyzed to determine whether one or more of the multiple forms of the enzyme were at an abnormal level. One isoenzyme at a high level may be compensated by another at a low level and the total isoenzyme concentration measured quantitatively would appear to be at a normal level despite such changes in the isoenzyme patterns.

Since there is skeletal muscle degeneration in CMT, one would have expected an increase in serum LD_5 since skeletal muscle is rich in this isoenzyme. However, lactate dehydrogenase banding patterns were essentially normal for all 14 specimens of CMT sera analyzed.

The appearance of an extra band in three of the CMT sera when the gels were stained for esterase is similar to the findings of Harris,[8] who observed polymorphism of cholinesterase in normal human serum. Harris noted an additional electrophoresis C_5 band from sera obtained from randomly selected normal adults. Only 4.6% of the sera which Harris studied showed this polymorphism which appears to be genetically determined; the extra band which appeared in the CMT serum after electrophoresis could be due to this polymorphism of cholinesterase.

In two CMT patients, two extra bands appeared after they were stained specifically for alkaline phosphatase. The main band which appears in normal serum is believed to be derived from the liver, but a second slow moving form also has been reported in the literature.[9] This second form of alkaline phosphatase has been shown to be under genetic control and it is thought to be of intestinal origin.[10] Since the two patients who had the extra alkaline phosphatase bands were brothers, the extra banding which did appear was probably due to their familial relationship and not to the neurological disorder. The percentage of CMT patients who had irregular isoenzyme patterns of esterase and alkaline phosphatase was small and these irregularities can be attributed to their genetic makeup and not to the neurological defect.

Eighteen CMT patients were surveyed to determine if they had diabetes mellitus, heart problems, or arthritis. All the CMT patients were ambulatory.

Friedreich's ataxia is an autosomal recessively inherited spinocerebellar degeneration.[11] A higher percentage (8%) of Friedreich's ataxia patients suffer from diabetes mellitus in England as compared with an incidence of diabetes mellitus of less than 2% in the general population.[12] The occurrence of diabetes mellitus in CMT was investigated in order to determine if a similar trend existed in this country. One CMT patient in our group of 18 was diabetic. This gives a higher percentage (5.6%) than in the normal population but requires further testing to establish any significance between diabetes mellitus and CMT.

Patients with Friedreich's ataxia also have been shown to have a variety of symptoms related to heart disease, such as heart enlargement, heart murmurs, and abnormal electrocardiograms.[13] Hewer found in his histological study of necropsy material from 27 Friedreich's ataxia patients that all the patients had associated heart involvement.[14] Only 2 of the 18 CMT patients had any problems related to the heart; one patient had a heart murmur while the other had coronary heart disease.

Nine of the 18 CMT patients were found to have arthritis which usually affected their hands or feet. The high incidence of arthritis in this group of CMT patients may be a coincidence or it could be a side effect of CMT. Any association between the two will be substantiated during investigations of additional CMT patients.

Summary

Peroneal muscular atrophy is a heredofamilial neurologic disorder which is more often manifested in childhood or adolescence. The clinical signs are pes cavus and muscle wasting which usually begins in the anterior muscles of the lower leg.

Quantitative and qualitative analyses of selected serum enzymes were initiated to determine whether an enzyme abnormality was present in the blood of patients with Charcot-Marie-Tooth disease. The raised levels of aldolase, lactate dehydrogenase, glutamate-oxaloacetate transaminase, and creatine phosphokinase were probably due to the release of these enzymes into the circulation resulting from the breakdown of muscle cell membranes. The percentage of CMT patients who had an irregular serum isoenzyme electrophoretic pattern was small.

Eighteen Charcot-Marie-Tooth patients were surveyed to determine if they had diabetes mellitus, heart problems, or arthritis. One patient was diabetic. Two patients had heart problems and nine patients were arthritic.

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Blood Glucose Control in Diabetes

This policy statement of the American Diabetes Association is intended to publicize the belief that the weight of evidence, particularly that accumulated in the past five years,[1] strongly supports the concept that the microvascular complications of diabetes are decreased by reduction of blood glucose concentrations.

For almost 50 years, since insulin therapy was initiated, proponents of "rigid," "tight," or "chemical" control quoted retrospective evidence of decreased or delayed nephropathy and retinopathy as glucose levels are brought by therapy toward the normal range. Opponents to this hypothesis pointed to the problems of complications in many of these supposedly better-controlled patients, to the emotional and socioeconomic conflicts which often resulted from the demands of rigorous control, to the frequent difficulties with hypoglycemic reactions, and, recently, to the University Group Diabetes Project.[2,3]

Five years ago, in a review of 300 reports in the world literature evaluating control, Knowles[4,5] found data from 85 centers which were satisfactory for analysis. There were no prospective studies which proved or disproved that control prevented complications, and definite studies had yet to be done. He concluded that better means must be developed to achieve control than those presently available.

The University Group Diabetes Project was initiated to help settle the controversy. The five forms of therapy failed to demonstrate any effect upon microvascular lesions.[2,3] The middle-aged or older subjects studied exhibited only minimal initial hyperglycemia, however, and the reduction in blood glucose was small, so the results are not directly pertinent to the relationships between glucose levels and microvascular lesions.

In the past few years, numerous studies in animals, including dogs, rats, monkeys, Chinese hamsters, mice, and others, have demonstrated that reduction of hyperglycemia by insulin therapy, by transplantation of insulin-producing tissues, or by other means, prevents or minimizes formation of diabetic-like lesions in eye, kidney, and nerve.[1] Biochemical studies have shown persistent hyperglycemia to be associated with accumulation of sorbitol in nerve, eye, and vascular tissue and with alterations in vascular basement membrane.[6] Most recently, even hemoglobin has been found altered in man and experimental animals in the presence of persistent and prolonged hyperglycemia.[7-11]

Biopsies of kidney (and in some studies of muscle) have failed to show abnormalities for the first few years to insulin-dependent diabetes in man,[12-14] excluding thereby an independently inherited phenomenon. In a small but prospective study of randomly assigned patients just reported from Paris,[15] enthusiastically well-controlled diabetic subjects showed less retinopathy. Thus, the contention that the microvascular complications occur independently of the hyperglycemia and insulin deficiency and that control of the metabolic events is not a factor in their progress does not appear tenable any longer.

These data therefore place the burden of proof upon those who maintain that diabetes control is without effect. The goals of appropriate therapy should thus include a serious effort to achieve levels of blood glucose as close to those in the nondiabetic as feasible. Obviously, patient needs and resources must also be carefully assessed and the goals individualized accordingly. This concept is particularly applicable to the diabetics as greatest risk of developing the microvascular complications—the young and the middle-aged. It is well appreciated, however, that in some juvenile-onset-type subjects, it is most difficult, even with multiple insulin injections, to achieve any significant degree of control of the hyperglycemia. Also, in certain elderly patients, the shorter life expectancy may preclude the need for achieving lower glucose levels, providing they are asymptomatic.

In summary, current clinical and experimental data clearly demonstrate that optimal regulation of glucose levels should be achieved in the treatment of diabetes, particularly in young and middle-aged individuals, who are at greatest risk of developing the microvascular complications.

It can be concluded that current means of therapy are only partly effective at best, and therefore a high priority must be assigned to the development of more physiologic insulin delivery systems or to approaches to the correction of the deficient insulin-producing mechanism itself. Finally, good diabetic management necessitates education and training of both patients and health professionals in the technics involved, and close coordination and cooperation in patient management. Most important is a commitment to the view that better "control," when achievable, is beneficial.

AMERICAN DIABETES ASSOCIATION
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Norbert Freinkel, MD, Vice-President: Professional Section

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The Use of Noninvasive Vascular Studies in the Diagnosis of Peripheral Vascular Disease

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THE CLINICIAN HAS several means of evaluating a patient with occlusive peripheral vascular disease. An appropriate history and careful physical examination[1] may allow the diagnosis to be made and the site of occlusion localized. Typically, a superficial femoral artery occlusion will be manifested by calf claudication. Aortoiliac occlusions will present as thigh or buttock claudication, although patients with lesions in either location may present with exercise claudication involving one or both extremities, rest pain, or a nonhealing trophic lesion. Various other stigmata of ischemic vascular disease, such as increased venous filling time, poor capillary refill, diminished extremity hair, dependent rubor, and thickened nails may or may not be present.

The patient's history and physical signs are frequently equivocal, and it is difficult to arrive at a definite localizing diagnosis by these means. Arteriography, which is now a widely available and safe method of study, can often resolve this issue.[2,3] But arteriography has drawbacks. In addition to requiring hospital admission, it is invasive, relatively expensive and uncomfortable, and it cannot be used repetitively in patient evaluation. Even though it provides a visual record of structural lesions, it gives no information on hemodynamics and changes which may be occurring with exercise. Although arteriography is indispensable in the final selection of patients for operative reconstruction, it is not justified in screening patients with limb pain due to musculoskeletal disorders, neuropathy, venous insufficiency, or malignancy. Not infrequently, these conditions are part of the differential diagnoses and need to be excluded.

Even in instances when the diagnosis of vascular disease has been confirmed, certain questions need to be answered. First, what is the location and severity of the vascular lesion? Is the lesion progressive and is limb-loss imminent? Is operation advisable and necessary? Can operative planning be aided and operative misadventure avoided by objective measurements?

The vascular laboratory at the University of Wisconsin Hospitals was established to assess patients with possible peripheral vascular disease by noninvasive techniques. Evaluations are based on the principles worked out by Strandness,[4] Yao,[5,6] Carter,[7] Raines,[8] and others.[9] This laboratory provides extremely helpful information in identifying patients with occlusive vascular disease among patients with extremity complaints. If both the ankle pressure and PVR are normal after exercise, one can be reassured that a patient's symptoms are not due to claudication. If chronic venous disease, musculoskeletal or neuropathic problems coexist with intermittent claudication, one can determine the contribution of the latter to the patient's symptoms.

Several types of instrumentation are used: The pulse volume recorder (PVR) is a quantitative plethysmograph which was developed by Raines *et al.* This instrument records the variation in limb volume caused by the arterial pulse. These variations are transmitted to a bladder in the occluding cuff, where the air pressure rises during systole and falls during diastole. Cuffs are placed as a blood pressure cuff would be around the thigh, calf, or ankle and inflated with a requisite volume of air to secure a

Figure 1—The pulse volume recordings have been previously obtained and sequential pressures are now being measured with assistance of the Doppler probe.

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good contact with the skin. A recording is obtained at a chart speed of 25 mm/sec. Normal patients have a pulse wave of increased amplitude following exercise. Patients with occlusive disease may show the following abnormalities: decrease in the rate of fall of the upstroke, rounding and delay of the pulse crest, decreased rate of fall of the downstroke, and absence of the dicrotic notch of the pulse wave.

The Doppler probe emits an ultrasound beam from a crystal excited by an electric oscillator. The probe makes contact with the skin using a gel, and the ultrasound beam passes through the walls of a blood vessel and is shifted in frequency by an amount proportional to the velocity of the blood in the vessel. The back-reflected sound is detected by a crystal adjacent to the first and amplified to produce an audible signal whose pitch is proportional to the velocity of blood in the vessel. By using a portable ultrasound flow detector (Doppler), one may accurately measure systolic pressure at the ankle level simply by using the sphygmomanometer in the usual way and the Doppler probe as a stethoscope. One may also use the Doppler to detect turbulent flow distal to an occlusive lesion—as over the common femoral artery in patients with iliac occlusions, since such turbulence is augmented after exercise because of increased limb blood flow. Also, arterial flow may be confirmed in instances where pulses are not palpable. The equipment is fully mobile, and can be utilized in the operating room, intensive care unit or recovery room as necessary.

A standard vascular laboratory examination is performed as follows: Peripheral pulses are examined and recorded, and pulse volume recordings at thigh, calf, ankle, and foot are made. Patients are then asked to walk on a treadmill at a controlled speed and at a minimal uphill angle (10°) for 5 minutes or until significant symptoms are produced—this is called the maximum walking time (MWT). Then thigh, calf, and ankle pressures are again measured, followed by sequential pulse volume recordings with notation of changes in amplitude and configuration, and recovery time to the preexercise values. All measurements obtained are correlated and interpreted by a peripheral vascular surgeon.

Figure 2—The treadmill shown here is used to evaluate anterior compartment syndromes as well as symptoms of claudication. Following exercise, pressures and pulse volume recordings are promptly reevaluated at the ankle level.

Patients presenting with intermittent claudication usually have less severe peripheral vascular disease than patients with rest pain or ulceration. Indeed, they may have resting ankle pressures that fall within the normal range, or may be so low as to overlap the range of patients with rest pain. In general, the addition of measurement of the ankle pressures and PVRs to a good physical examination provide the most helpful of the vascular laboratory examinations and correlate well with the severity of disease.

If true claudication exists, both ankle pressures and PVR determinations will be abnormal after exercise, since patients with a significant occlusive lesion cannot augment limb blood flow sufficiently across their occlusion to sustain pressure in the presence of the decreased peripheral resistance produced by muscular exercise. When true claudication is present, one can then establish a quantitative baseline for sequential examinations. In a group of 87 patients with claudication who were unable to walk more than 200 yards, the average resting pressure of 77 mmHg fell to 24 mmHg with exercise; and the pulse volume recordings reflected comparable severity of their disease.[10] As a result of this research patients whose ankle pressures fall to below 50 mmHg after exercise can be considered to have met the quantitative criterion for a diagnosis of limiting claudication.

Patients with nonlimiting claudication can be safely followed without operation, and should be encouraged to exercise, lose weight, and especially to abstain from cigarette smoking. Their progress can be quantitatively measured at yearly or half-yearly intervals by repeated vascular laboratory testing. This is a far less expensive and a more appropriate method of follow-up than repeated arteriograms. In fact, the majority of such patients can be expected to remain stable or to improve.[11] While in the past many underwent reconstructive arterial surgery, they may now be safely followed, a strategy amply supported by both the natural progression of femoral-popliteal occlusive disease and the results of operations for femoral-popliteal bypass. However, close follow-up is critical should the patient's condition deteriorate precipitously or should mildly symptomatic rest pain progress to pregangrene. Should such disease progression occur, it can be quantitated by vascular laboratory studies, and reconstructive surgery planned without delay.

Because of difficulty in using a stethoscope on distal vessels, blood pressure measurements in the lower extremities are not commonly performed. Yet, in normal individuals the systolic blood pressure measured at the ankle should be equal to or slightly greater than the brachial artery systolic pressure. If

resting ankle pressures are below brachial artery pressure, the difference, or gradient, indicates an occlusive lesion somewhere in the aortofemoral system. However, patients with occlusive lesions may have a normal resting pressure which will fall with exercise, just as they may have normal distal pulses only to have these disappear with exercise.[12] In practice, the ankle pressure at rest may be abnormally low or within the normal range. Predictably, patients with minimal disease such as those with intermittent claudication are more likely to have systolic pressures which fall within the normal range, while those with more advanced occlusive disease have lower pressures at rest. Among 74 patients with rest pain, the average resting ankle systolic pressure was 36 mmHg.[10] Other investigators also have found low ankle pressures in patients with rest pain.[13,14] The pressure is important since it represents the perfusion pressure of the distal lower extremity at rest. Resting ankle pressures in diabetic patients average about 20 mm higher than nondiabetic patients because of calcification of peripheral vessels, and in about 5%-10% of diabetic patients ankle systolic pressures cannot be determined due to incompressible vessels.[10]

Another group of patients may be felt to have gangrene requiring amputation when they actually have surgically correctable pregangrenous changes. Measurement of ankle pressures and pulse volume recordings can assist in identifying and treating this group of patients. Finally, there are some patients with more advanced peripheral vascular disease who require lower extremity amputation. One strives to select the most distal amputation possible. Transmetatarsal amputation is optimal since it allows ambulation without a prosthesis and allows the patient to wear normal shoes. Below-knee is preferable to above-knee amputation since it permits easier prosthesis fitting and easier turning in bed, and bed to chair transfers. Yet one would not want to perform a distal amputation through tissue that will not heal, since morbidity and mortality are substantially increased when failure of a distal amputation necessitates a more proximal one. Vascular laboratory studies can complement even the most careful clinical evaluation by providing certain quantitative data helpful in choosing the appropriate level of amputation.

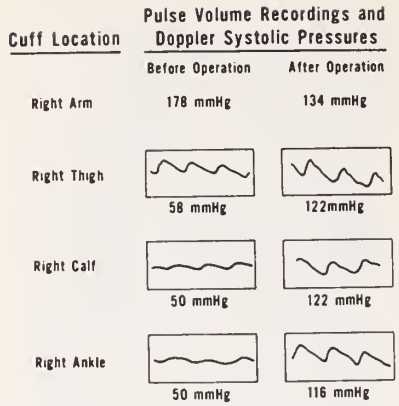

Figure 3—These findings were obtained in a 53-year-old diabetic man with pregangrene of the right foot. Preoperative tracings and pressures are shown on the left while postoperative data is on the right. No pulses were present below the groin before operation and a dorsalis pedis pulse is now present. Note the nearly systemic pressures after vascular reconstruction. This gives a valuable baseline for following the patient.

Healing of a BK amputation will be likely if calf pressures are greater than 65 mmHg and ankle pressures greater than 30 mmHg with good quality PVR, probable with poorer quality PVR and these pressures, and unlikely with calf pressures under these values.[10] Yao found that a thigh pressure of 80 mmHg was predictive of healing of a below-knee amputation, while pressures below this level were associated with failure and subsequent need to a more proximal amputation.[6]

Small digital cuffs also are available which can be helpful in diagnosis and management of vasospastic disease and upper extremity vascular problems. Application of these techniques is still in the research phase, but early results suggest the possibility of substantial improvement in the management of these patients.

The noninvasive vascular laboratory has been useful in helping to confirm the clinical impression of occlusive peripheral vascular disease and in helping to prepare patients for reconstructive arterial surgery. It also has been useful in the operating room as a means of detecting technical errors during vascular operations so that these

ABSTRACT WISCONSIN AUTHORS

Interstitial Lung Disease Due to Contamination of Forced Air Systems

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Eight patients had symptoms suggestive of hypersensitivity pneumonitis associated with contamination of their home or office forced air heating or air conditioning systems. The clinical and laboratory features of the patients were studied and the results indicated that the disease could occur as an acute or an insidious form differing in type and intensity of respiratory and systemic symptoms. Thermophilic actinomycetes contaminating the forced air systems were identified as the sensitizing agents in most cases. Precipitating antibodies to the organisms could be shown in the serums of the patients and the antigen identified by immunofluorescent studies in the three lung biopsies examined by this method. Inhalation challenge studies with the cultured organism or other materials obtained from the forced air systems reproduced the clinical syndrome in the four patients tested. Avoidance of the contaminated system, and the use of corticosteroids in more severe cases, seems to be appropriate therapy for patients with this disease. ■

can be corrected before the procedure is concluded. Intraoperative arteriograms may be obviated in some circumstances. We have been gratified by the usefulness of noninvasive techniques in monitoring postoperative patients in the recovery room and intensive care units. We continue to utilize these noninvasive techniques to follow patients managed without operation as well as those who have undergone arterial reconstructions.

The application of noninvasive vascular laboratory studies has obvious implications for the primary care practitioner faced with the responsibility for the proper management of individuals with limb pain. Utilization of these quantitative techniques permits the vascular surgeon to provide more objective data to the primary physician.

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ABSTRACTS WISCONSIN AUTHORS

Lack of Efficacy of Thermography As a Screening Tool for Minimal and Stage I Breast Cancer

MYRON MOSKOWITZ, MD; JOHN MILBRATH, MD; PETER GARTSIDE, PhD; ALFONSO ZERMENO, PhD; and DAVID MANDEL, BA, Univ of Cincinnati College of Medicine; Medical College of Wisconsin; and Univ of Texas, MD Anderson Hospital:

N Engl J Med 295:249-252 (July 29) 1976

In a study of thermograms of 42 patients with Stage I or smaller carcinomas of the breast, 44 confounding cases and 64 randomly selected subjects being screened, we found that the ability of expert thermographers to identify the patients with carcinoma correctly (true positive = 0.238) varied little from the ability of untrained readers (true positive = 0.301). Furthermore, in the expert group, the indexes of suspicion were so high (0.436) and the true-positive levels were so relatively low (0.238 P = 0.0005) that thermography may well have a very limited role as a screening or prescreening modality for the detection of minimal or Stage I breast cancers. ■

Simultaneous Multiple Organ Support

BURTON A WAISBREN, MD, FACP, St Mary's Hospital, Milwaukee, Wis:

Hospital Practice, May 1976, pp 102-112

Doctor Waisbren describes the experience of a medium-size (292-bed), general hospital and observes that patients in a critical care unit seldom die of the failure of a single organ system. A multiple organ support might thus very well result in saving a significant number of lives. In order to institute multiple organ support a critical care unit must have the following modalities and facilities: multiple arterial blood gas determinations; direct measurement by transducers of arterial and venous pressures; measurement of pulmonary artery and wedge pressures; determination of cardiac output by thermodent dilution; determination of levels of electrolytes, lactic acid, clotting elements, cortisol, blood volumes, weights, and colloid osmotic pressure; acute hemodialysis with surgeons at hand who can place good shunts; a volume respirator in which positive end expiratory pressure (PEEP) is an easily added modality; an intraaortic balloon pump; and a hyperbaric oxygen tank and a well-trained crew. Doctor Waisbren writes that these modalities are in the range of a moderate-size hospital and believes that they should be in every general hospital with an active emergency room, for adequate treatment of cases of myocardial infarction, poisonings, smoke inhalation, pulmonary failure, and severe trauma.

The indication for multiple organ support is in a situation in which the patient will probably die of multiple organ failure and in which his physician feels justified in going all out to save him. Since all the modalities employed are accepted forms of treatment, their use in combination should not be considered extraordinary or "investigational."

Multiple organ support is indicated in four main types of patients: the young individual with burns over 80% of his body, patients in Gram-negative shock, patients in cardiogenic shock who are either being prepared for surgery or who are potentially salvageable but not surgical candidates, and young patients with the adult respiratory syndrome.

Doctor Waisbren concludes that from the standpoint of staff morale and pride, the endeavor is worthwhile. "It is a great feeling for all who take part to realize that they can function as a team to salvage a patient otherwise fated to die from the emergency condition that brought him to the hospital."—VSF ■

The Prone Chest Film

BRUCE SIMONDS, MD, PAUL J FRIEDMAN, MD, and JOEL SOKOLOFF, MD, Dept of Radiology, University of California - San Diego, LaJolla, Calif:

Radiology 116:11-17 (July) 1975

Frontal chest radiographs in the prone position enhanced visualization of the posterior lung base in the presence of pleural effusions. Though the lateral decubitus view often displaced fluid adequately, in several cases only the prone film revealed basilar lung pathology; this was due to gravitational shift of the fluid away from this region as well as improved aeration of the lower lobe in the prone position, as shown by horizontal-beam lateral views. The prone chest film is recommended for evaluation of the lung base when obscured by fluid.

Doctor Simonds currently practices in Bruce, Wisconsin. Doctor Friedman is Professor of Radiology and Acting Chairman, Dept of Radiology, UC; he received a BS degree in 1955 from the University of Wisconsin. ■

Dermatofibrosarcoma Protuberans, An Uncommon Tumor

John J Smalley, MD, FACS, LaCrosse, Wisconsin

• **Dermatofibrosarcoma protuberans is a tumor with a high degree of recurrence associated with definite invasive capabilities and, rarely, a potential for systemic dissemination. The diagnosis can often be made clinically by its gross appearance and a high index of suspicion. When viewed in conjunction with the clinical features, the microscopic picture of a hypercellular spindle cell tumor with a "cart wheel" configuration is quite diagnostic. It is apparently not possible to predict a metastatic potential based on histologic criteria.**

DERMATOFIBROSARCOMA protuberans is an uncommon tumor of fibrous tissue origin characterized by a marked propensity to local recurrence and an infrequent incidence of distant metastases. These tumors are usually associated with the skin surface.

The earliest description of this disease was published in 1890 by R W Taylor, who described a nodular, lobulated, intracutaneous tumor in a 43-year-old male. Subsequently in 1924 Darrier and Ferrand[1] provided the classic paper depicting precisely this clinical entity. Hoffman[2] in 1924 named this entity a dermatofibrosarcoma protuberans. Numerous reviews of the subject have been published; the most significant are listed in the bibliography. Stout[3] originally included these neoplasms in the fibrosarcomas of the skin. Later O'Brien and Stout[4] considered these tumors in the group of storiform fibrous xanthomas. However, in recent years it has been generally agreed that the dermatofibrosarcoma is a separate tumor.

From the Department of Surgery, St Francis Hospital, LaCrosse, Wisconsin.

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Case Reports

Case 1. A 42-year-old male auto mechanic presented with the chief complaint of a nontender mass present on the medial aspect of the right thigh for approximately one year. He described the initial presentation as a lesion about the size of a fingernail, slightly raised, and plaque-like. It had proceeded to increase in size over the ensuing months. Positive physical findings were limited to the mass located just above the right knee on the anteromedial aspect of the thigh (Fig 1). The tumor was approximately 6.5 cm wide at its base and protruded above the skin surface approximately 4 cm. The overlying skin was tense and shiny without ulceration. No satellite nodules were noted. The lesion was freely movable over the underlying fascia, although there was some suggestion of involvement of the surrounding subcutaneous tissue. No palpable inguinal adenopathy was present.

A clinical diagnosis of dermatofibrosarcoma protuberans was made. The patient subsequently underwent a wide excision of the lesion including the underlying fascia, and the resultant defect was closed with a split-thickness skin graft. Histologic examination of the tumor confirmed the clinical diagnosis. After four years there has been no evidence of recurrence.

Case 2. A 14-year-old female presented with complaints of a mass present in the left buttocks area for approximately a year and a half. The patient was uncertain as to the exact beginnings of the lesion, and did not appreciate its presence until it had grown to approximately 2 cm size. The mass had slowly enlarged over the previous several months. Clinical examination revealed a nodular raised lesion of the left buttocks measuring 9 cm in its greatest diameter. The mass appeared to be unattached to the underlying deep fascia, and was nontender. No other significant physical findings were present. Preoperatively a diagnosis of dermatofibrosarcoma protuberans was made, and subsequently the patient underwent surgical excision of the lesion with wide margins (Fig 2), and the resultant defect was closed with a skin graft. Histologic examination confirmed the clinical impression of dermatofibrosarcoma protuberans.

Discussion

The exact incidence of this tumor in relation to all soft tissue tumors is difficult to quantitate; some idea of its frequency, however, may be appreciated from the following:

> Pack and Tabah[5] reported 39 patients from Memorial Hospital accrued over a twenty-year period. More recently, McPeak[6] *et al*, from the same institution, reported 86 cases seen in a period of 18 years. This increase in the number of tumors was proportional to an increase in the total number of patients seen at the hospital within this period. Fifty-six patients were seen at the Mayo Clinic[7] between 1913 and 1963. Taylor and Helwig's[8]

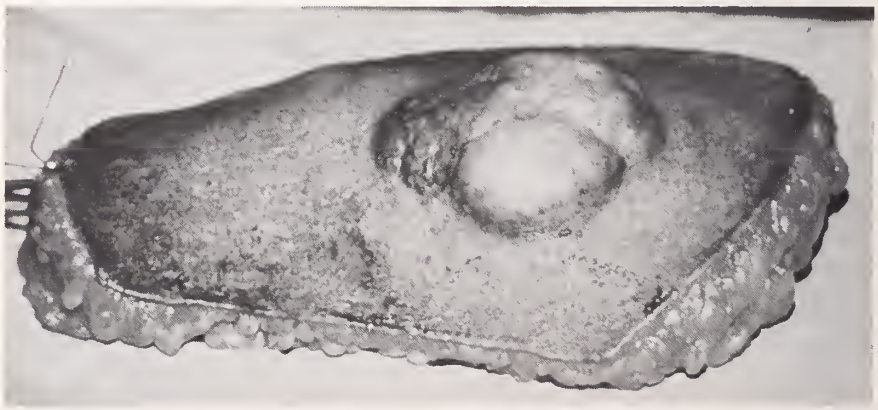

Figure 2—Case 2 showing modular lesion and proposed outlines for excision.

Figure 1—Case 1 showing typical projection of the tumor above the skin surface.

series from the Armed Forces Institute of Pathology listed 115 patients.

Males are more commonly afflicted than females, in a ratio of about three to two. This disproportionate number of males seen in Taylor and Helwig's series most certainly reflects the case source; *ie,* the Armed Forces. The age of onset varies widely (5 - 70+ years) but the majority occur between 20 and 50 years of age. No racial predilection has been noted.

These tumors commonly occur in the trunk, but all skin areas are known to have been involved.

The initial finding in the majority of patients is a small, firm, cutaneous nodule or lump, often with red or blue discoloration. Characteristically, growth of the lesion is slow and often other satellite nodules develop and coalesce. As growth progresses, the skin overlying the lesion becomes tense and atrophied. Pain or tenderness is uncommon, and when present, is often related to the size or location of the lesion. There is considerable variation in the duration of disease as given in the history of the patient. Although a few are seen early, the vast majority of patients have had their lesions for more than several years and many for longer than ten.

As previously mentioned, dermatofibrosarcoma protuberans manifests itself as single or multiple nodules on the skin surface. They are firmly attached to the skin and the majority are confined to the dermis and subcutaneous tissue. The epidermis is generally stretched thinly over the lesion and erosions or ulceration may be present. On cut section the lesion is ligneous and resistant. It is composed of glistening grayish-white homogenous tissue, occasionally with a somewhat dirty yellowish cast. Pseudo-encapsulation is due to a condensation of fibrous tissue at the periphery. The growth seldom invades the underlying fascia, tending to infiltrate in a horizontal plane through the corium and subcutaneous fat. There is a marked proclivity of the tumor to extend in fine projections well beyond the apparent margins of the gross specimen.

These tumors are composed of fairly uniform spindle-shaped cells which can produce collagen. Vascular spaces are present in a varying degree and are lined by a single layer of endothelium. Myxoid areas may be prominent, particularly in recurrent lesions. Attention has been called to a characteristic pattern of cellular arrangement in these tumors. This "cartwheel" or "whirligig" appearance consists of spindle cells arranged about a central collagenous area (Fig 3). While not pathognomonic, inasmuch as it has been seen with other tumors, for example, schwannoma, this cartwheel pattern when coupled with a clinical correlation usually will provide for accurate diagnosis. Hypercellularity of this tumor is a constant finding and of no prognostic value in terms of recurrence or metastases. McPeak[6] *et al* felt that when the number of mitoses per high-power field exceeds eight, it is an ominous finding in respect to future metastases. However, this observation requires substantiation.

There have been several schools of thought regarding the histogenesis of this lesion. Stout and Lattes[9] felt that the tumor cells were not fibroblasts derived from fibrocytes, but rather were frustrated fibroblasts derived from histiocytes. Bednar[10] considered the pattern to be a feature of neurogenic tumors. Hashimoto *et al*[11] felt that electron microscopic studies favored a histogenesis from the endoneural or perineural cell rather than from histiocytes or Schwann's cells.

Before arriving at a diagnosis of dermatofibrosarcoma protuberans, the following soft somatic tissue tumors must be considered:

Lipoma or liposarcomas. Usually subcutaneous lipomas are readily differentiated by their soft mobile character. The differentiation from a liposarcoma may occasionally be a problem.

Fibrosarcoma. This is by far the most important tumor to differentiate from a therapeutic and prognostic standpoint.

Neurofibroma. It can be quite difficult to exclude, because in a solitary neurofibroma the clinical as well as microscopic features can often remarkably resemble a dermatofibrosarcoma protuberans. Often however, presence of other stigmata of Von Recklinghausen's disease will enable one to make an accurate diagnosis.

Kaposi's idiopathic hemorrhagic sarcoma. May occasionally be a source of confusion, but these lesions occur characteristically on the hands and feet. Dermatofibrosarcoma, on the other hand, has a predilection for the trunk and uncommonly involves the distal extremities.

Excluding these forms of tumors, occasionally amelanotic melanoma, melanoma arising in a blue nevus, sclerosing angioma and some rare dermatologic conditions (for example, dermatomyositis) may create a difficulty in making an accurate clinical diagnosis. It is apparent, therefore, that an accurate histological diagnosis is mandatory prior to planning the management of these patients.

Treatment

Although other modalities of

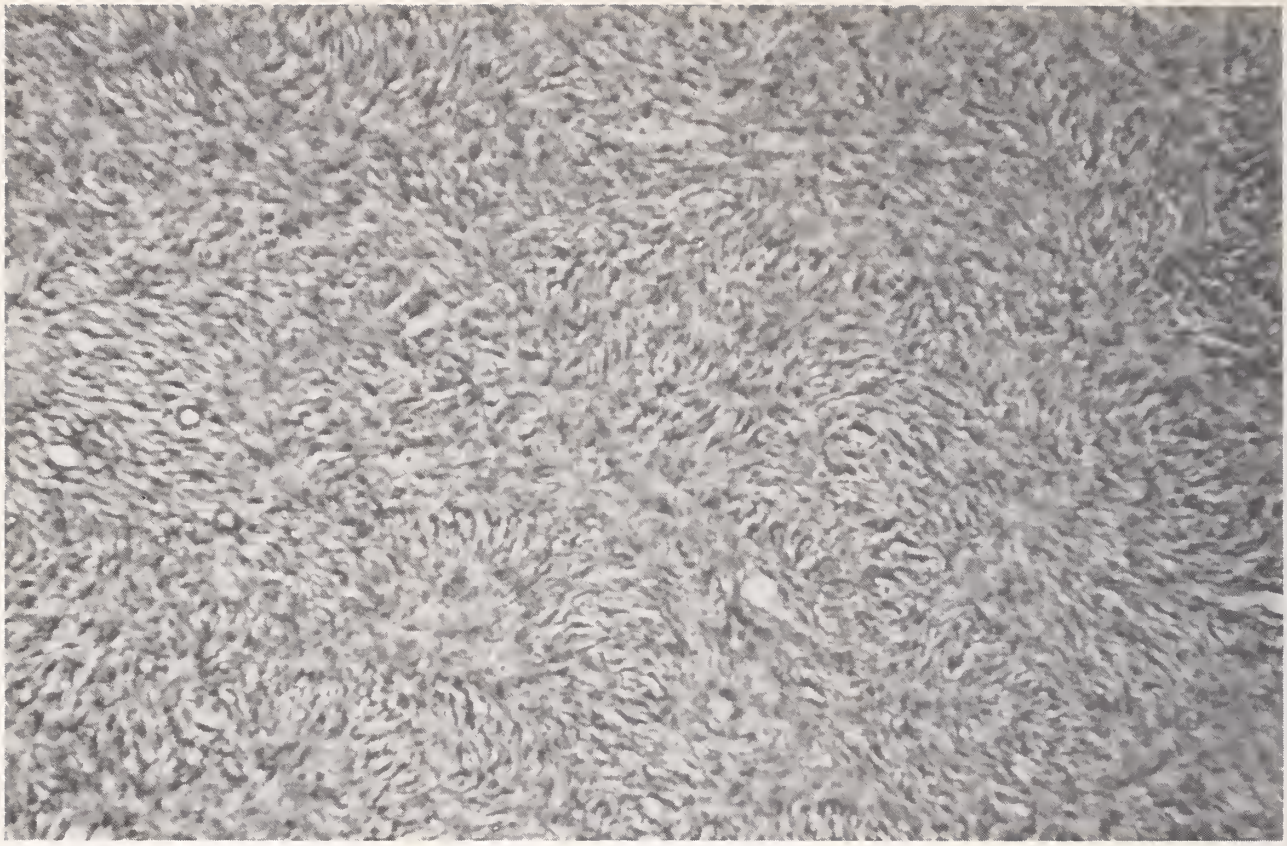

Figure 3—Shows typical "cart wheel" or "whirligig" appearance. (H & E X180).

therapy have occasionally been used, surgery is the treatment of choice. This tumor responds well to adequate wide excision in a three-dimensional plane, including underlying fascia. Coverage of the resultant defect is ordinarily accomplished with a skin graft. If indicated, the excision may include underlying muscle, fascia or bones. A similar viewpoint has been expressed by Phelan and Juardo from Roswell Park Memorial Institution.

The incidence of local recurrence is directly proportional to the adequacy of the initial excision. In the latest Memorial Hospital[6] series, 21 patients had a collective total of 75 recurrences prior to their admission to Memorial Hospital. Twenty-four of the 56 cases reported by the Mayo Clinic[7] had a collective total of 80 recurrences. It is doubtless that the high incidence of recurrence is often a function of iatrogenic error.

This tumor is by nature a slow growing, indolent lesion. As with all neoplasms possessing infiltrative capacity, the adjacent muscle and fascia are invaded by it with the passage of sufficient time. This is more commonly seen in lesions of the face, scalp, and neck. Several fatalities have been reported due to the direct invasion of the brain by recurrent tumor of the scalp.

Recurrences, as noted, are common following inadequate excision. Late lymph node metastases have been seen.[12] Distant metastases, while rare, have been documented. The case reports of distant metastases have indicated that these follow multiple operations for recurrent tumor. It may be that the biologic behavior of these tumors is altered with recurrences. It is therefore evident that initial curative resection would diminish the incidence of metastatic disease.

Following adequate wide excision, the chances of a complete cure are more than 99 percent. However, inadequate excision results in local recurrence as mentioned above, which might result in metastatic disease and a certain percentage of these patients, albeit a few, will die of dermatofibrosarcoma protuberans.

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Spontaneous Necrosis in Pituitary Adenomas with Associated Meningitis

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• **Two patients had spontaneous necrosis of pituitary tumors with associated meningitis. Such changes in pituitary tumors frequently masquerade as meningitis or encephalitis with consequent delays in correct diagnosis and therapy. These case reports demonstrate both the difficulty in differential diagnosis and that the two disease entities may coexist.**

COMPREHENSIVE reviews of acute degenerative changes in pituitary tumors have emphasized the wide variety of associated signs and symptoms.[1-6] From these reviews it is apparent that earlier diagnosis and newer methods of endocrinologic and surgical management have produced a significant reduction in a previously high morbidity and mortality.

Numerous cases of "pituitary apoplexy" have been reported in which the predominant symptoms were those of an acute inflammatory meningeal or encephalitic process with associated cerebrospinal fluid pleocytosis in patients with an acute, rapidly progressive, unexplained intracranial disorder. Because this condition can mimic or be associated with subarachnoid hemorrhage or meningitis, appropriate therapy may be delayed if the possibility of pituitary apoplexy is not kept in mind.

Recently we treated two patients with bacterial meningitis and spontaneous necrosis of previously undiagnosed pituitary tumors.

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Case Reports

Case 1. A 52-year-old man was admitted in December 1974 for the evaluation of severe nonpulsatile bifrontal headache of abrupt onset and with associated nausea and vomiting.

On admission he was alert and neurologically normal. He became progressively more lethargic. The next day his temperature was 38.9 C (102 F), the neck was stiff and blood pressure was 80/60 mm Hg. There was a bitemporal hemianopsia but otherwise the neurologic examination was normal.

The cerebrospinal fluid was yellow and cloudy with mildly elevated pressure. The fluid contained 8200 red blood cells, 1800 white blood cells (85% polymorphonuclear leukocytes), 68 mg/100 ml protein, and 62 mg/100 ml glucose. No organisms were seen and culture was sterile. Skull x-ray films showed enlargement of the sella turcica. Steroid therapy and supportive care were instituted.

The following day the patient's lethargy increased and cerebral angiography was performed. Except for moderate spasm of the supraclinoid portion of the left internal carotid and anterior cerebral arteries, no significant abnormalities were visible.

On the fourth day the patient was alert, oriented and vital signs were stable. Two days later his temperature rose to 38.9 C. Subsequently, he complained of severe bifrontal headaches and became more obtunded. Blood cultures grew Serratia. Another lumbar puncture was done which demonstrated diminished pleocytosis, Gram-negative rods were seen on smear, and the culture grew Serratia. Steroids were increased and antibiotics were administered systemically and intrathecally.

Repeat cerebral angiography indicated moderate ventricular dilatation. The following day the patient was unresponsive to pain, the pupils dilated and respirations ceased. Immediate respiratory assistance and a ventriculostomy for external drain were instituted. Spontaneous respirations returned as did withdrawal from stimuli. The patient remained stable and the ventriculostomy was removed.

On the seventeenth day, a similar episode occurred but ventriculostomy was not followed by significant improvement. Because suprasellar extension of tumor or clot could have contributed to the progressive obtundation, a transsphenoidal tumor removal was performed. Following incision of the dura, a hemorrhagic necrotic mass was removed by dissection and suction. Intraoperative pneumoencephalogram did not indicate suprasellar extension. On histologic examination of this tissue, fragments of eosinophilic necrotic tissue with foci of hemorrhage were seen as were acute and chronic inflammatory cells. The patient did not improve. He died one week later.

Pertinent autopsy findings were acute purulent leptomeningitis, softening of the right subcortical nuclei and a small amount of clotted blood in the basilar cisterns. Sections through the sella turcica showed evidence of the previous surgery and rare collections of cells compatible with chromophobe adenoma. Adjacent to the hemorrhagic areas, the tissues show severe infiltration by inflammatory cells and occasional micro-abscesses. The walls of large vessels in the area were invaded by neutrophils.

Case 2. A 28-year-old male presented in May 1975 with a three-day history of rapidly progressive nonpulsatile retro-orbital headache associated with nausea, vomiting, diplopia on left lateral gaze, numbness of the right side of the face and photophobia. Prior to this illness he had been without symptoms. Vital signs and general physical examination were normal except for a temperature of 40 C (104F) and mild nuchal rigidity. A Marcus-Gunn pupil was present on the right. Visual fields and visual acuity were grossly normal. There was no papilledema. Bilateral sixth nerve paresis and trigeminal hypalgesia and hypesthesia were observed. During the next hour the patient became increasingly lethargic and complained of decreasing vision. He now had a right third nerve paresis. Vision was reduced to detection of hand motion in the right nasal field and was 20/800 on the left. Pupillary reaction to light was minimal on the right and normal on the left. Deterioration continued with the patient becoming progressively obtunded despite episodes of combativeness.

The hemoglobin was 12.4 gm/100 ml and the white blood cell count was 16,000/cu mm with a left shift. The rest of the laboratory evaluation was unremarkable. Skull x-ray films revealed enlargement of the sella and erosion of the anterior and posterior clinoids.

Cerebrospinal fluid pressure was 300 mm of water. The fluid was cloudy with 1300 red blood cells/cu mm, 1200 white blood cells/cu mm, protein of 63 mg/100 ml, glucose of 54 mg/100 ml (blood glucose 108 mg/100 ml). Although no organisms were seen, cultures grew pneumococcus. Steroid and antibiotic therapy was begun.

Cerebral angiography revealed mild enlargement of the curvature of the cavernous and supraclinoid portions of the internal carotid arteries and elevation of the circuminfundibular plexus. Moderate spasm of the supraclinoid carotid was present. No evidence of aneurysm or tumor was seen.

Because of the deteriorating clinical course, a transsphenoidal tumor removal was done. The sphenoid sinus and floor of the sella turcica appeared intact. Following the dural opening, a hemorrhagic and necrotic mass not under any significant pressure was removed by dissection and suction. Histologic examination of this material showed large areas of necrotic tissue with much acute inflammatory cell infiltration. In a few small areas, better preserved tissue was characteristic of chromaphobe adenoma.

On the second postoperative day, the patient was alert, oriented, and had progressive visual improvement. Visual acuity was 20/400 on the right and 20/800 on the left. The third and sixth nerve palsies had cleared. Visual field examination revealed a right incongruous homonymous heminanopsia. Progressive improvement continued and a pneumoencephalogram fifteen days after surgery demonstrated filling of the chiasmatic cisterns without evidence of surpasellar extension. At discharge, visual acuity was 20/20 on the right and 20/80 on the left. Visual fields were unchanged.

Discussion

An apoplectiform illness resulting from spontaneous necrosis or hemorrhage in a pituitary tumor is usually manifested by varying occurrences of headache, nausea, emesis, alterations in states of consciousness, ocular nerve palsies, variable loss of visual acuity, facial hypalgesia, fever, and signs of meningeal irritation. These signs and symptoms are an unusual presentation of a pituitary tumor which is usually associated with slowly developing neurologic and endocrinologic abnormalities. Many cases of pituitary apoplexy may go unrecognized because of the rapid course from onset to death, and therefore estimation of the true incidence is difficult. Wright[2] emphasized the dismal results of such cases prior to modern medical management. He reported on 85 cases collected from the literature of which only 10 survived.

It is evident from the observations of Wright and others that early recognition is necessary to achieve maximum therapeutic benefit. Because the clinical picture may suggest subarachnoid hemorrhage,[5,8] cerebral angiography may be required. In many instances cerebrospinal fluid pleocytosis, fever, and nuchal rigidity are the predominant clinical findings, and the correct diagnosis will not be made unless skull films are obtained. In many of these patients, antibiotic therapy was given because of the preliminary diagnosis of meningitis.[3,6,7] Delays in arriving at a definitive diagnosis were usually short but in some instances were long enough for permanent loss of vision to occur.[3] Although the meningitis in most cases of pituitary apoplexy may be chemical, even the demonstration of bacteria in the cerebrospinal fluid, as in Case 2, does not exclude the possibility of pituitary tumor. Consequently, skull films have been advocated in all cases of bacterial meningitis.[6]

Erosion of the sella floor by an expanding tumor may result in tumor growth into the sphenoid sinus providing a route of entry for bacteria into the intracranial space. The finding of pneumococcal meningitis not associated with any systemic infection strongly indicates such a mode of transmission in Case 2. It is also possible that the subsequent inflammatory reaction within the pituitary region resulted in tumor necrosis.

Although recovery without surgical intervention has been reported,[2,9] continued neurologic deterioration, especially progressive loss of vision is a strong indication for removal of the acutely necrotic pituitary tumor. Our second patient had a successful early transsphenoidal tumor removal. The first patient was operated upon at a much later period in his illness without benefit. If tumor removal becomes necessary, the transsphenoidal approach appears to be the most suitable operation. Because it is basically an extracranial procedure, the complications of the transcranial approach are avoided, including aggravation of arterial spasm and coexisting infection.

Conclusion

Two case reports of spontaneous necrosis of a pituitary tumor with a coexisting bacterial meningitis have been reported. The meningitis in the first patient appeared as a secondary complicating factor whereas in the second case the inflammatory process was the probable precipitating event. Acute hemorrhagic necrosis in pituitary tumors frequently presents as meningitis or encephalitis and unless the correct diagnosis is made promptly, the necessary treatment may not be started soon enough to be effective.

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SUPPORTED BY THE WISCONSIN PERINATAL CENTER, SOUTHCENTRAL REGION, MADISON

EDITOR: Luis B Curet, MD, Professor, Department of Gynecology-Obstetrics, University of Wisconsin Center for Health Sciences-Madison General Hospital, Madison, Wisconsin

The first meeting and training session for "genetic contacts" representing every county in the State of Wisconsin was organized on December 8, 1976 in Madison by the Genetics Section of the Diagnostic and Treatment Unit, Waisman Center, University of Wisconsin, Madison, through a grant awarded by the Developmental Disabilities Council of Wisconsin.

"Genetic contacts" comprise some physicians, mostly public health nurses, developmental disabilities coordinators, social workers, psychologists and home trainers, who will help to increase awareness throughout the State of the professional and general public of genetic facilities available and of the role they can play in the prevention of severe genetically determined conditions through investigations, management, counselling and/or prenatal diagnosis.

They will be helped to recognize indications for genetic services and types of families at risk who could benefit from them. Should such families and their physicians request genetic help, the "contacts" will have at their disposal central referral procedures through which immediate services can be provided to any family in urgent need. It is hoped also that in the future it will be possible, with the help of "genetic contacts," to organize traveling "satellite" genetic clinics in more remote areas of the State.

The Fetus at Risk in Wisconsin

Frederick G Sehring, MD, Green Bay, Wisconsin

We have known for a long time, that certain fetuses are at greater risk than others. Rh iso-immunization, diabetes mellitus, toxemia, and chronic renal disease may lead to fetal death before birth; morbidity also is increased in these infants. Perinatal physicians are increasingly aware of the need to lessen neonatal mortality and morbidity.

The social consequence of failure is mammoth. The cost of custodial care in Wisconsin is now approximately $19,000 per patient per annum. If a newborn is damaged but survives with a life expectancy of only 40 years, the minimum lifetime cost would be $760,000. Such computations do not begin to measure the potential productive loss to society of a useful nondamaged newborn, or the pain and suffering to the family of the damaged child.

In addition to the "classical" high-risk obstetrical conditions, other minor factors may be cumulative in a given patient. Thus, a mother who is 36 years old, single, obese, and has a hemoglobin of 9 gm/100 ml may be at significant risk, although each risk factor alone might seem relatively benign.

A simple fetal risk scoring system was developed by three Toronto obstetricians (Doctors Goodwin, Dunne, and Thomas[1]) and statistically analyzed by Dr William Hebb in Nova Scotia.[2] Dr William Powers of the Southcentral Perinatal Region initiated fetal risk scoring research in Wisconsin in 1975. With the assistance of University biostatisticians he began computerizing data obtained from select hospitals in the Southcentral region, utilizing a modified Goodwin system.

In October 1975, the Northeastern Wisconsin Perinatal Center began promoting throughout its service area use of this method of fetal risk assessment. St Vincent Hospital, Green Bay, has utilized such "scoring" for almost one year with individual physicians using the system in their offices and clinics.

The scoring system, which produces a score of 0 to 10 (10 indicating greatest risk) incorporates pertinent data from three sources: (A) Baseline Prepregnancy information, (B) Prenatal observations prior to onset of labor, and (C) Gestational Age at the onset of labor. A maximum of three points can be scored in Category A and B whereas Category C (Gestational Age) may total at most four points. The system is relatively simple, like the Apgar Score, well known to obstetricians, generalists, and pediatricians.

In a five-year prospective study in Nova Scotia, the system has been used by over 40% of physicians practicing obstetrics. Most instances of fetal and neonatal mortality and morbidity could be predicted by this method. By assessing only categories (A) and (B), Doctor Hebb and his associates were able to idenitfy a group (14% of all patients) having a score of 3-6. Fifty-four percent (54%) of the stillbirths, fifty-seven percent (57%) of the neonatal deaths, and forty-two percent (42%) of the prematures could have been predicted in advance by using this system.

It is hoped that this system or a modification applicable to Wisconsin can be implemented in each per-

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inatal region and statewide so that health professionals rendering maternal and newborn care can concentrate more time and effort on the identifiable high-risk population. In this manner, hopefully, we can significantly reduce perinatal mortality and morbidity in Wisconsin without expending unnecessary physical, economic, and health professional resources.

It is possible with a fetal risk scoring mechanism, prospectively applied, to reduce fetal and neonatal mortality much as the retrospective use of maternal mortality studies by the Maternal Mortality Committee has reduced maternal deaths.

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ABSTRACTS: WISCONSIN NEUROLOGICAL SOCIETY

FROM SPRING MEETING—MADISON, MAY 28-29, 1976
Raymond W M Chun, MD, Secretary-Treasurer, Madison

Action EEG and the Diagnosis of Epilepsy

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Since epilepsy is the sudden excessive disorderly discharge of the gray matter and since this discharge is electrical, it is important to correlate the electroencephalographic (EEG) changes with the clinical picture. The mere presence of the EEG abnormality, albeit paroxysmal, does not make the diagnosis of epilepsy.

The correlation of the clinical condition with the EEG changes is best accomplished by audiovisual (AV) tape recording during seizures using the split screen technique showing both the patient and the EEG. We have been applying this for some eleven years now. Selections are made from the tape recordings of ten patients to illustrate particular points in this regard.

The film presentation from these AV tapes is divided into two parts. The first part shows nonepileptic phenomena unaccompanied by an EEG dysrhythmia. A vasovagal syncope syndrome is presented. This was erroneously diagnosed as a seizure disorder brought on by viewing unpleasant medical sights. A hyperventilation syndrome, narcoleptic attacks in a patient with brain damage, and pseudoseizures evoked by a particular kind of music are also demonstrated.

No paroxysmal EEG changes were detected in these four patients. The patient with vasovagal syncope showed only EEG slowing at the time of decreased cerebral blood flow.

The second part of the film shows specific illustrative instances of patients with epilepsy and the accompanying EEG recordings. A patient with a specific wave spike dysrhythmia is shown with interruptions of clinical activities during the "absence" or petit mal attack. An unusual instance of wave spike dysrhythmia of relatively short duration was shown in a patient who had a prolonged period of slow mentation and confusion. Also is shown a wave spike dysrhythmia in a patient carrying on clinical activities and without an accompanying seizure. One patient had a temporal lobe spiking dysrhythmia. When he was reading aloud there were breaks in reading indicating aphasic seizures. Another instance of temporal lobe dysrhythmia is shown. The patient had described his seizures as momentary episodes of aphasia. However when recorded, the seizures are partial complex or psychomotor seizures of minutes duration. The seizures therefore were much more severe than he was aware. Finally a patient with a partial complex psychomotor seizure is shown. He had no accompanying EEG dysrhythmia. The clinical features of the seizure and the postictal weakness on the left side of the body demonstrated the true nature of the seizure, despite the absence of EEG changes.

This paper shows therefore nonepileptic phenomena without significant EEG changes, epileptic phenomena occurring with significant EEG changes, epileptic phenomena occurring without EEG significant changes, and EEG dysrhythmia without clinical seizures. Moreover this paper also demonstrates the variance between the patient's accounts and the actual severity of the seizure.

This paper stresses the importance of the personal role of the electroencephalographer in the diagnosis of epilepsy. It indicates the need for caution in relying preponderantly on the laboratory (EEG) for the diagnosis of epilepsy. ■

Neuronal Ceroid Lipofuscinosis—Clinical and Pathologic Studies

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Neuronal ceroid lipofuscinosis, or Batten's disease, is a degenerative disease of the central nervous system characterized by the accumulation of the autofluorescent pigments, ceroid and lipofuscin, in neurons. A specific biochemical defect has not been identified. The storage materials are nonspecific indicators of cellular damage. These materials have recently been found in a number of accessible extracerebral tissues. Other clinical findings are the peripheral blood smear and the ophthalmological abnormalities.

A 6-year-old boy with diminished visual acuity and early mental deterioration had characteristic atrophic and pigmentary retinal changes. An older sister has the chronic form of the disease. The peripheral smear contained vacuolated lymphocytes. Sea blue histiocytes, containing autofluorescent pigment, were seen in the bone marrow. A skin fibroblast was found on electron microscopy to contain numerous amorphous bodies characteristic of lipofuscin. Peroxidase activity of leukocytes was 10 percent of normal, a finding reported in other patients which may represent a useful biochemical test for the disease.

Batten's disease has clinical characteristics and morphological abnormalities in peripheral tissues. These should be of great help to the clinician in making a diagnosis of Batten's disease without the need of a brain biopsy. ■

Subcutaneous Implantation of an Adenocarcinoma Following Thoracentesis

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THORACENTESIS is a routine procedure indicated in patients with pleural effusion of unknown etiology. The chemical, cytologic, immunologic, and bacteriologic characteristics of the fluid can thereby be determined; and a rational approach to the diagnosis and treatment of patients with diseases of the chest can be undertaken. Thoracentesis may also be therapeutic when used to relieve effusions associated with respiratory impairment; and in the presence of a tumor, repeated thoracentesis with instillaton of chemotherapeutic or sclerosing agents is sometimes required to control the reaccumulation of the fluid.

Complications following thoracentesis are uncommon. Pneumothorax is the most frequently observed, while less frequently seen complications include hemothorax, empyema, air embolism, vasovagal reaction, and intercostal artery damage. Seeding of tumor cells through a needle tract after a thoracentesis has been described twice previously.[1,2] This complication also has been observed after both pleural[3-6] and lung needle biopsies.[7-10] The purpose of this report is to describe a third case of subcutaneous implantation of the tumor after thoracentesis and to discuss the implications of this unusual complication.

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Case Report

A 58-year-old black female was admitted to the medical service of Milwaukee County General Hospital in June 1972 because of anorexia and a weight loss of 39.6 kg (18 lb) during the previous six months. Severe weakness, progressive dyspnea on exertion and dry cough had been noted for one week.

On admission, the patient was moderately thin and in mild respiratory distress. Dullness to percussion over the lower two-thirds of the right lung with absence of breath sounds were noted. Thyroid, breast, and pelvic examinations were within normal limits. There was no adenopathy.

The initial chest x-ray film showed a large right pleural effusion with complete opacification of the lower two-thirds of the right hemithorax. Hemogram, SMA-12, urinalysis, syphilis (VDRL), and thyroid function tests were normal. PPD 5TU test for tuberculosis was negative after 48 hours. Radiographic findings in the gastrointestinal and urinary tract were normal, and a roentgen bone survey was negative. Thyroid, liver, spleen, and bone scans were within normal limits. Proctoscopic examination and cul-de-sac fluid aspiration were also negative.

On the day of admission, thoracentesis yielded 1500 ml of serosanguineous pleural fluid. The cytologic examination was positive for adenocarcinoma cells. A pleural biopsy was not done. Because of reaccumulation of the effusion, five subsequent thoracenteses were carried out with the instillation of chloroquine three times, and thiotepa (Lederle) twice into the pleural cavity.

Six months later the patient was readmitted, complaining of dull pain in the right side of the chest. During the physical examination a single fixed firm nodular mass, 7 cm in diameter, was found at the level of the 7th and 8th right intercostal space in the posterior axillary line. Overlying the mass were multiple needle scars from previous thoracenteses (Fig 1). A needle biopsy of this mass revealed a poorly differentiated adenocarcinoma (Fig 2). The patient had local radiation with complete resolution of the mass. Her condition gradually deteriorated, and she died in April 1973. An autopsy was not performed.

Comment

Implantation of tumor cells through a thoracentesis needle tract is an infrequent complication, with only two cases being previously reported in the literature.[1,2] In one case the subcutaneous metastasis was evident six weeks after the procedure;[2] in the other, the time interval was not reported.[1] In the

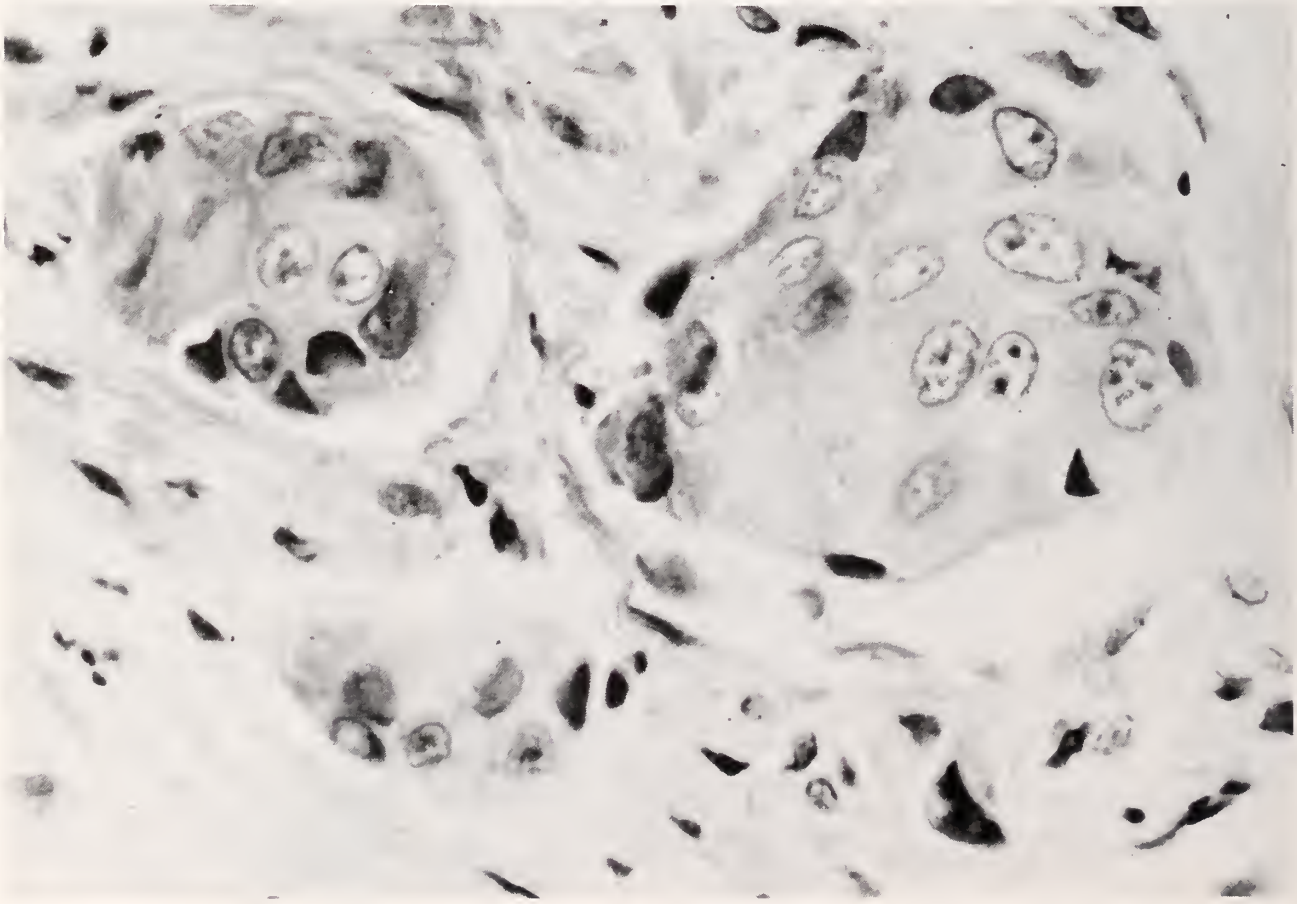
present case a subcutaneous metastatic nodular mass was found five months following repeated thoracentesis for instillation of chemotherapeutic agents for the treatment of a malignant pleural effusion.

Several factors are involved in the initial subcutaneous seeding of tumor cells. These include the presence of neoplastic cells in the effusion; the needle size (*i.e,* large needles increase the possibility of tumor cell adherence which would then be transferred to the subcutaneous tissue at the time of extraction);[11] and the number of procedures done.[9] Subcutaneous seeding of neoplastic cells has been observed, however, following a single thoracentesis.[2] Factors involved in the subsequent growth of the implanted cells to an evident metastasis include the length of time the patient survives following a thoracentesis. The development of a pleural effusion is often a late event in the evolution of lung cancer, and in many instances there may not be enough time for growth of the implanted cells. The most important, but least understood, factor regarding tumor cell growth involves the immunocompetence of the host. Experimentally implanted tumor cell lines in the subcutaneous tissue of normal subjects fail to grow, while implantation of these cell lines in cancer patients has led to the development of a metastatic nodule.[12]

The same mechanisms involved in the spread of tumors through thoracentesis needle tracts also apply in cases of biopsies of pleura, lung, thyroid, and prostate tissues. Four cases each of implantation of

Figure 1 — Appearance of the right posterior subcutaneous chest wall mass. Arrow indicates needle scars of previous thoracentesis.

Figure 2 — Histologic specimen of the subcutaneous lesion at the right posterior chest wall. Poorly differentiated adenocarcinoma cells are present. (Hematoxylin and eosin; magnification 500X).



a tumor through subcutaneous tissue following a needle pleural biopsy and following a lung needle biopsy have been described.[7-10] Additionally, two cases of seeding of neoplastic cells in the pleural cavity after a lung biopsy have been described.[13]

While the lung needle biopsy has been condemned by several authors because of the possibility of converting a resectable lesion into a nonresectable one by the spread of tumor cells to the adjacent normal tissues, the same is not true in the case of a thoracentesis or a pleural needle biopsy. Neoplastic cells in pleural fluid or a positive pleural biopsy for malignancy are considered to be evidence of unresectability, because these findings indicate the spread of the tumor cells throughout the pleural surface.

Thoracentesis provides essential information in the diagnosis of pleural effusions of unknown etiology. The fact that neoplastic cells may be found in the fluid indicates that the tumor is not resectable. Thus, the unusual complications of subcutaneous seeding of neoplastic cells and their growth as a metastatic tumor in the needle tract does not contraindicate, in any event, the performance of a diagnostic or therapeutic thoracentesis.

Summary

A patient with subcutaneous implantation of tumor cells of an adenocarcinoma following repeated thoracentesis has been presented. Although a pleural effusion with positive cytology is considered a contraindication to curative surgical treatment, the risk of seeding neoplastic cells following thoracentesis is not a contraindication of the procedure.

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Testicular Seminoma

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• This report describes the pathological and clinical features of testicular seminoma. Methods of treatment and survival data are discussed. The results of treatment of testicular seminoma at the University of Wisconsin Radiotherapy Center from 1959 to 1975 are discussed. Fifty-eight patients were treated. Fifty-two had typical seminoma; five had anaplastic seminoma, and one had spermatocytic seminoma. The survival for typical seminoma for patients at risk five years was 93%.

MALIGNANT testicular neoplasms are rare in comparison to other malignancies in males. Since relatively young patients with potentially long survival are affected with these tumors, a thorough knowledge of the diseases is mandatory to ensure proper evaluation and treatment. The purpose of this article is to review management and treatment of one histological type of testicular tumors—seminoma. Results of treatment at the University of Wisconsin Radiotherapy Center will be discussed.

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Epidemiology

The incidence of testicular tumors in the United States is 2.1-2.2 per 100,000 males. The United States Census Bureau attributed 0.64% of all male cancer deaths to testicular tumors while in England the comparable rate was 0.52%. Seminoma comprises from 35-71% of testicular tumors. The frequency depends upon the type of hospital reported in various studies. Seminoma, embryonal carcinoma, teratoma, and teratocarcinoma are common in young adults, but seminoma is more frequent in the fourth decade.[1]

Pathology

Seminoma by definition is a germ cell tumor composed of large uniform cells with clear cytoplasm. These characteristic cells resemble

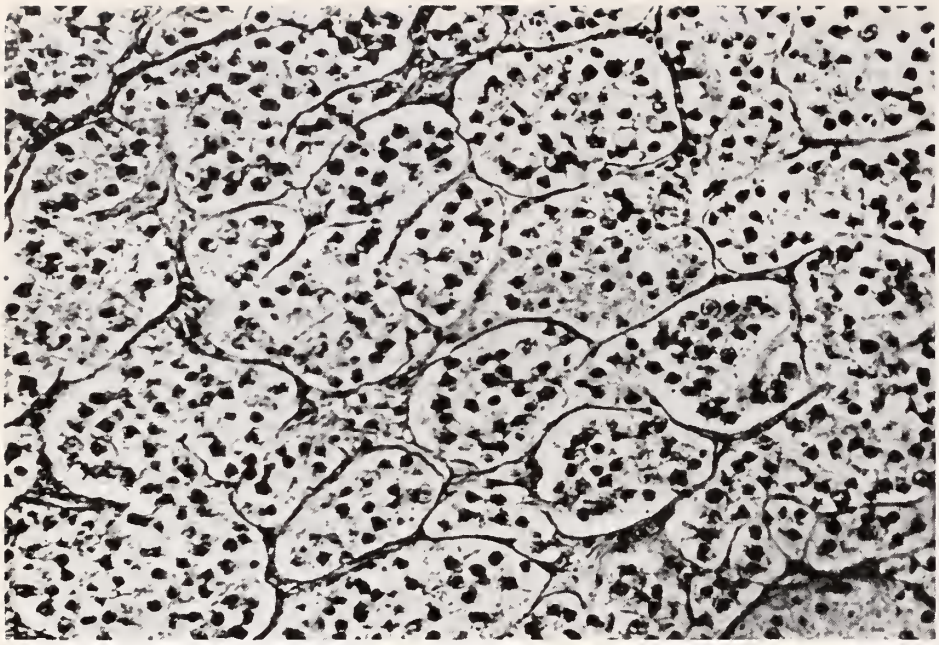

Figure 1 — Photomicrograph of typical seminoma showing uniform cells supported by a delicate fibrous stroma (x180).

primordial germ cells and are supported by a fibrovascular stroma with varying amounts of lymphocytic infiltration and granulomatous stroma. The pathological classification of seminoma is divided into three subtypes: typical or classical seminoma, anaplastic seminoma, and spermatocytic seminoma.

Typical seminoma and the anaplastic seminoma have the same gross characteristic appearance. The testicular enlargement is usually diffuse. The cut surfaces are grayish-white lobulated tissue. Grossly the spermatocytic seminoma is yellow, soft, and slightly mucoid. Spongy and cystic areas are common.[2]

Histologically typical seminoma is composed of uniform cells supported by a delicate fibrous stroma (Fig 1). Lymphocytic infiltration is marked in only about 20% of cases but occurs in varying degrees in almost all seminomas. Granulomatous reaction occurs in half the cases and is marked in 20%. Seminoma cells are large, polyhedral, or round, and have a distinct cell border. The cytoplasm is clear or granular. Nuclei are large, centrally located, spherical, hyperchromatic and have an irregular nuclear membrane. Mitotic figures are infrequent and little variation is seen in the size and shape of cells.[2]

Anaplastic seminoma demonstrates cellular irregularity with variations in size, shape, and staining of the nuclei. The nuclei are also more vesicular and larger than those of typical seminoma. An average of three or more mitotic figures per high-power field is recommended to justify the designation as anaplastic seminoma. Increased mitoses is the most reliable feature.[2]

Three cell types are found in spermatocytic seminoma. The majority of cells are medium sized with a spherical nucleus and eosinophilic cytoplasm. The other two cell types include lymphocytic-like cells and large mononuclear cells. A filamentous arrangement of chromatin in the intermediate and large cells is similar to that in the meiotic phase of normal primary spermatocytes.[2]

Clinical Features

Testicular malignancies afflict young adult men. The average age of patients with testicular seminoma in larger series ranges from 30 to 40.[1,3-6] Mostofi[1] described an incidence of previous history of undescended testes in 3.6% of 2,000 patients with testicular tumors. It has been estimated that malignancies develop in undescended testes at a rate 10 to 14 times greater than in normally descended testes.[1] Seven percent of the 277 cases of testicular seminoma described by Maier and associates[3] had a history of maldescent in the involved testicle.

The most common symptom is enlargement of the testicle. Most often the enlargement is painless. Rarely a patient with an undescended testicle will present with an inguinal mass. The differential diagnoses of a testicular mass includes epididymitis, hernia, hydrocoele, or spermatocoele. Occasionally the symptoms of metastatic disease will cause a patient to seek medical consultation.

Anatomical Considerations and Staging

Seminomas spread predominantly via lymphatic channels. Therefore, a thorough knowledge of the lymphatic drainage of the testes and other scrotal contents is mandatory. The lymphatics of the testicle drain into the ipsilateral periaortic and pericaval lymph nodes in the lumbar region which lie at a level just at or below the level of the renal veins. The lymphatic vessels of the ductus deferens pass to the external iliac nodes, and those of the seminal vesical drain partly to the hypogastric and partly to the external iliac nodes. The lymphatic drainage of the scrotal skin is to the inguinal nodes. Drainage of all structures is generally unilateral and cross-over rarely occurs. Previous inguinal surgery such as a herniorrhapy or an orchiepexy causes interruption of normal lymphatic drainage. Regenerating lymphatics after such surgery may ultimately result in cross drainage to the contralateral inguinal or iliac node groups.

Mediastinal and supraclavicular node metastases are the next step of drainage from the lumbar periaortic nodes. Supraclavicular nodes, especially those on the left, may be involved without mediastinal nodal metastases. This mediastinal skip is

Figure 2A — Pretreatment abdominal x-ray film with intravenous pyelogram taken the day after lymphangiogram was performed. Arrows show enlarged lymph nodes interpreted as having seminoma metastases.

Figure 2B — Follow-up abdominal x-ray film taken ten months after treatment. Involved areas were treated to 3600 rads. Arrows show lymph nodes which have decreased in size and indicate a favorable response to therapy. The patient is alive at five years post treatment without evidence of disease.

often demonstrated by bipedal lymphangiography.

Staging of testicular tumors is based on the natural lymphatic spread described above. Stage I disease is confined to the testicle. Stage II involves metastases to the first echelon of lymphatic drainage, the periaortic nodes or other subdiaphragmatic lymph nodes. Stage III indicates metastatic disease to mediastinal or supraclavicular nodes. Stage IV indicates more extensive disease (Table 1).

Diagnosis and Pretreatment Evaluation

Orchiectomy with high ligation of the spermatic cord employing an inguinal incision should be used to provide tissue for the diagnosis. A scrotal approach should not be done because this procedure puts the scrotal skin at risk for subsequent metastases.

If the diagnosis of testicular malignancy is suspected, preoperative hematological and chemical surveys, and intravenous pyelogram, a urinalysis, and chest x-ray films are warranted. A serum HCG titer also should be done.

Once the diagnosis of testicular malignancy has been established, a bipedal lymphangiogram is absolutely necessary. This study is invaluable in the management of testicular neoplasms. It aids the radiation therapist in treatment planning by helping direct radiation ports. Inferior venocavography was previously a part of the evaluation but

Table 1 — Staging of seminoma

STAGE I
The cancer is confined to the testicle. This determination is made by clinical and radiographic studies and by orchiectomy.

STAGE II
There is clinical or radiographic evidence of metastases to periaortic, iliac, or inguinal lymph nodes or microscopic evidence in the orchiectomy specimen of invasion beyond the testicle.

STAGE III
There is clinical or radiographic evidence of metastases to mediastinal or supraclavicular lymph nodes.

STAGE IV
Metastases are more widespread than in Stage III.

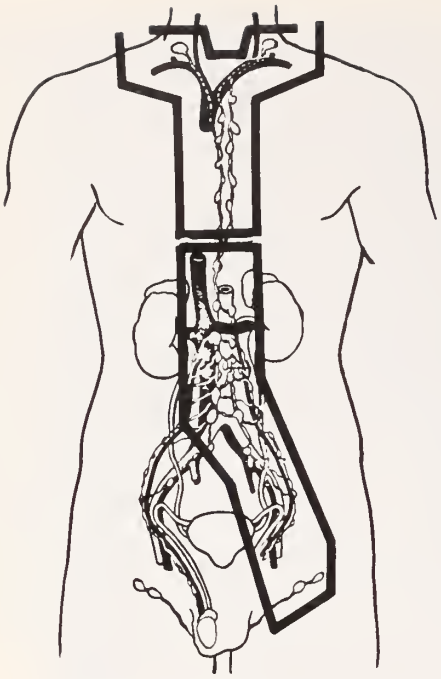

Figure 3 — The subdiaphragmatic field is treated anteriorly and posteriorly. Para-aorta, iliac, and inguinal nodes are encompassed. These lymph node chains are routinely irradiated in Stages I and II. The supradiaphragmatic radiation fields treat the mediastinal and supraclavicular nodes. These fields also are treated anteriorly and posteriorly in Stages II and III.

has been replaced by bipedal lymphangiography which is more accurate in diagnosing nodal metastases. Follow-up abdominal x-ray studies are routinely taken after treatment at regular intervals so that response of metastases can be monitored. (Figs 2A and 2B).

Bipedal lymphangiography is highly accurate in diagnosing nodal metastases. Since 1964, 108 patients with testicular neoplasms have undergone bipedal lymphangiographic examination at the University of Wisconsin Medical Center. A total of 45 non-seminoma cases had histological correlation which was made at the time of retroperitoneal node dissection. The accuracy of the interpretation was (28/29) 97% if the study was read as positive and 12/16 (75%) if the study was read as negative. The overall accuracy was (40/45) 89%.

Treatment

Radiation therapy is the treatment of choice for seminoma after the radical orchiectomy has been performed. The treatment varies according to stage of disease.

At the University of Wisconsin Radiotherapy Center, all patients are treated with megavoltage radiation using either Co60 or 4 MeV linear accelerator which deliver comparable energies of radiation. Patients with Stage I disease receive elective irradiation consisting of 3000-3600 rads midline dose in three to four weeks to ipsilateral inguinal-iliac and bilateral periaortic areas. Anterior and posterior fields are employed (Fig 3). Other authors advocate additional elective irradiation in Stage I patients to include treatment to the mediastinum and supraclavicular regions.[6,7]

The Stage II patients with moderate sized or less than 10 cm in diameter periaortic nodal metastases are treated with radiation fields as described for Stage I. Massive or greater than 10 cm in diameter metastases to the periaortic or iliac areas were previously treated only with these fields. However, during the last four to five years when the disease has been massive, whole abdominal irradiation to a dose of 1500-2000 rads in two to three weeks has been used first followed by the usual fields to the periaortic and inguinal-iliac areas. Total doses to massive disease range between 3500 and 4000 rads.

In addition all Stage II patients received elective irradiation to the mediastinum and supraclavicular areas. Since bipedal lymphangiography occasionally demonstrates bilateral supraclavicular node filling, both supraclavicular fossae are routinely irradiated. Elective doses range from 2000 to 3000 rads over a period of two to three weeks.

Treatment of Stage III patients consists of radiotherapy to the same areas as described for Stage II. Stage IV patients receive therapy which is individualized depending upon the location and extent of disease. Anaplastic seminoma and spermatocytic seminoma have been treated in the same manner as typical seminoma.

Results

The success of the treatment of seminoma has paralleled the development of modern radiotherapy. Before 1930 the five-year survival rate for all testicular tumors was probably less than 30%.[4] In Sir Gordon Taylor's series[8] of cases treated up to 1943 the survival rate at three years was 58% for seminoma. This initial improvement followed the routine use of postoperative irradiation of the periaortic nodes. With better tumor localization methods such as lymphangiography and more sophisticated megavoltage irridation equipment the cure rate in seminoma has further

Table 3 — Survival in patients with anaplastic seminoma treated at the University of Wisconsin Radiotherapy Center

	2 YR	3 YR	5 YR
Stage I	3/4	2/3	1/2
Stages II, III ..	none	—	—
Stage IV	0/1	0/1	0/1

Table 2 — Survival in patients with classical seminoma by stage of disease treated at the University of Wisconsin Radiotherapy Center

	1ST YEAR	2ND YEAR	3RD YEAR	5TH YEAR
STAGE I	36/36	32/32	20/20	19/19
STAGE II	13/14	10/11	10/11	8/9
STAGE III	1/1	1/1	1/1	1/1
STAGE IV	1/1	0/1	0/1	0/1
OVERALL	51/52 (98%)	43/45 (96%)	31/33 (94%)	28/30 (93%)

improved. Large series consistently have reported overall five-year cure rates in seminoma of 85% or better.[3,5,7,9-12]

From January 1959 to February 1975, 58 patients with the diagnosis of testicular seminoma received their initial postorchiectomy irradiation at the University of Wisconsin Hospitals Radiotherapy Center. Fifty-two patients had typical seminoma; five had anaplastic seminoma, and one had spermatocytic seminoma. There were only two deaths from typical seminoma. A patient with Stage II disease died of seminoma four months after treatment, and a Stage IV patient died at 23 months.

The overall survival for all stages of typical seminoma at two, three, and five years is 96%, 94% and 93% (Table 2). The single patient with spermatocytic seminoma died at 119 months of unrelated causes.

The survival of patients who received their initial treatment for anaplastic seminoma is shown in Table 3. One Stage I patient died at six months with pulmonary metastases. The Stage IV patient presented with peritoneal carcinomatosis and died after the first day of treatment.

Complications Side Effects of Treatment

The usual symptoms of abdominal cramping and occasionally mild diarrhea were seen in patients receiving subdiaphragmatic irradiation. Symptoms of esophagitis occurred in some patients who received mediastinal and supraclavicular treatment. Severe complications such as radiation-induced transverse myelitis are potential risks. But proper calculation of gaps between radiation fields prevents such a problem. There have been no severe complications or treatment related deaths in the University of Wisconsin series.

Discussion

In the University of Wisconsin series no recurrences were seen in typical seminoma or anaplastic seminoma after two years. Doornbos and associates[9] have shown in a larger series that 95% of recurrences in typical seminoma appear within 36 months. Our data support this finding.

Survival in Stage I typical seminoma cases is 100%. Maier[4,8] has been the leading proponent of supradiaphragmatic irradiation in Stage I seminoma patients. The University of Wisconsin experience and other large series show comparable survival rates without the additional prophylactic treatment.[5,9-11] This evidence indicates that additional prophylactic irradiation to the mediastinum and supraclavicular areas is unjustified in Stage I patients.

Other authors have stated that anaplastic seminoma has the same prognosis as typical seminoma when the diseases are compared stage for stage.[3,12] Two of five patients with anaplastic seminoma who received their primary care at the University of Wisconsin have died of disease as compared with only two deaths in 52 patients with typical seminoma. In addition, another Stage I anaplastic seminoma patient who received appropriate initial treatment elsewhere was referred to our institution with metastatic disease and ultimately died from it. A review of the experience at the University of Wisconsin and a critical analysis of previous reports in the literature indicates that anaplastic seminoma has a worse prognosis when compared with typical seminoma stage by stage.[13]

Summary

Testicular seminoma is divided into three histological subgroups: typical, anaplastic, and spermatocytic seminoma.

Seminomas afflict young adult men with potentially long-term survival. A painless testicular mass is the most common presenting symptom. Seminomas metastasize via lymphatics and rarely hematogenously. Staging is related to lymphatic spread of disease. Pretreatment evaluation is directed at evaluating the extent of disease. Lymphangiography is an indispensable part of the examination.

Radical orchiectomy followed by radiation therapy to appropriate areas is the treatment of choice. Five-year rates of 90% or better are attainable without serious complications. Improvement in the treatment has paralleled the development of radiation therapy as a separate clinical specialty.

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Isolated Fourth Cranial Nerve Palsies: Etiology and Prognosis

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• Twenty-three cases of isolated fourth nerve paralysis at the Marshfield Clinic were reviewed. Trauma accounted for nine cases (39%), diabetes and vascular disease eight cases (34.7%), and undetermined three (13.3%). The majority of cases from all causes resolved in three to four months. Those that persisted more than four months were usually permanent. The majority of patients were male and the age of the patient correlated with the cause (trauma under 60, vascular over 60). Almost all those secondary to trauma resolved, while only 60% of those secondary to vascular disease resolved.

ISOLATED SUPERIOR oblique muscle palsies are a relatively rare condition and one which is often overlooked when testing extraocular movements. The literature is quite limited on this subject. The etiology of this condition has been somewhat speculative and no correlation between etiology and prognosis has been presented previously. Therefore, we have reviewed our experience at the Marshfield Clinic in order to gain some insight into these questions.

Materials and Methods

All patients who were diagnosed as having superior oblique palsies from 1969 to March 1976 were reviewed. From this group, only those with isolated unilateral or bilateral superior oblique palsies were included. Twenty-three patients fulfilled the criteria of isolated fourth nerve palsy. The diagnosis was made or confirmed in all cases by a Board certified ophthalmologist. The records were reviewed and relevant data relating to onset, duration, and etiology were gathered. Where follow-up was incomplete, telephone contact personally by one of the authors (HW) was used to complete the record and check on recovery by the patient.

Results

The population studied consisted of 23 patients. There were 17 males and 6 females. All were adults except for one child age seven. The average age was 55.3 years and the median age was 58 years. There were two cases of bilateral trochlear nerve paralysis. Of the 21 cases of unilateral involvement, 11 involved the right side, 10 involved the left side.

Our findings show there to be multiple causes of trochlear nerve paralysis. Nine cases were due to trauma. Eight cases were associated with diabetes, hypertension, or other vascular disease. One case was associated with tumor, a mesothelioma (L) chest wall. One case was congenital, and one occurred postcraniotomy for clipping of carotid aneurysm. The cause was undetermined in three patients.

Discussion

In Table 1, our data are compared with the major studies of isolated trochlear nerve palsy previously reported in the literature.[1-4]

Trauma was the most common cause of isolated trochlear nerve palsy in all studies. Vascular disease made up the second most common cause in our group, as was true of Burger's series[1] and Rucker's first series.[3] Undetermined etiology was the third most common in our series, and made up a large group in the other reported studies[2-4] with the exception of Burger's series.[1]

Tumors made up a significant part of Burger's patients[1] and were well represented in Rucker's second paper.[4] Tumors were not found in our experience as a cause of trochlear nerve palsies. Other isolated cases in the literature included multiple sclerosis, neonatal hypoxia, aneurysm, congenital postintracranial surgery, lupus erythematosus, collagen disease, herpes zoster ophthalmicus, encephalitis, stroke following heart valve surgery, ethmoidectomy, acute mastoiditis, and tetanus.[1-7]

Anatomy: See Figure 1 outlining the anatomy of the trochlear nerve and susceptibility to injury, secondary to trauma.

The fibers from the fourth cranial nerve nucleus at the level of the

Table 1 — Fourth cranial nerve palsies — etiology. Literature review.

Study	Number	Trauma	Diabetes and Vascular	Tumor	Undetermined	Other
Burger, et al Miami 1970	33	13 (39.5%)	6 (18.4%)	7 (21.2%)	2 (6.1%)	5 (15.2%)
Khawan, et al San Francisco 1967	40	27 (67.5%)	2 (5.0%)	1 (2.5%)	8 (20.0%)	2 (5.0%)
Rucker Mayo Clinic 1958	67	24 (35.8%)	24 (35.8%)	3 (4.5%)	9 (13.4%)	7 (10.5%)
Rucker Mayo Clinic 1964	84	23 (27.4%)	13 (15.5%)	7 (8.3%)	28 (33.3%)	13 (15.5%)
Wright, et al Marshfield Clinic 1976	23	9 (39.0%)	8 (34.8%)	0 (0.0%)	3 (13.0%)	3 (13.0%)

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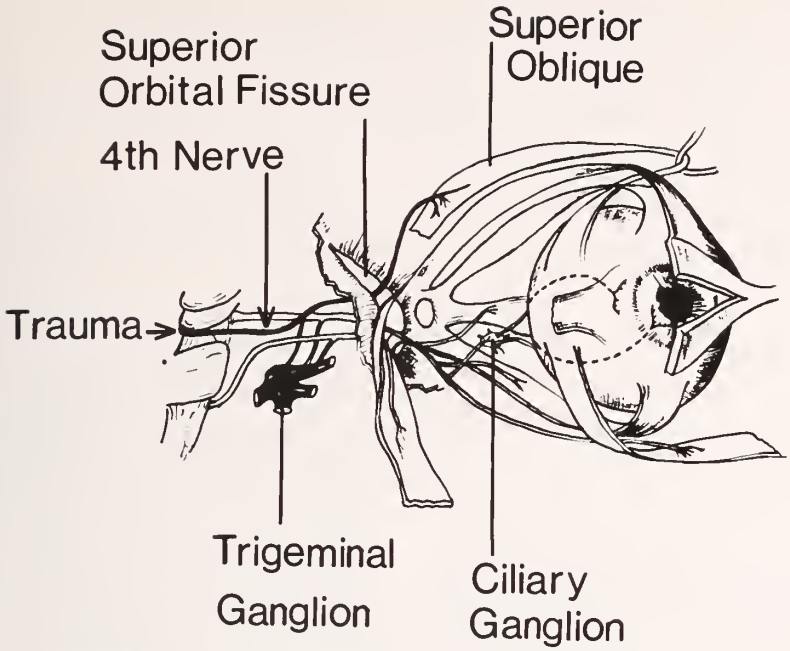

Figure 1 — Anatomy of the fourth cranial nerve (Trochlear).

inferior colliculi course dorsally and laterally about the central grey substance to decussate completely in the roof of the mesencephalon. They emerge just behind the inferior colliculi. After the fibers emerge from the central nervous system (CNS), they pass anteriorly and ventrally about the superior margins of the cerebral peduncles. They pass in the subarachnoid space to the base of the brain stem, where they pierce the dura and enter the cavernous sinus just behind the level of posterior clinoid process. The trochlear nerve is associated with the third and sixth cranial nerves in the cavernous sinus. It enters the orbit through the superior orbital fissure, then innervates the superior oblique muscle.

The dorsolateral midbrain is particularly vulnerable in severe frontal impacts against the accelerated skull. The mechanism of this injury is thought to be that the brain stem is thrust against the posterior lateral edge of the temtorium. The contusion is usually accompanied by hemorrhage as the primary lesion from the impact. The injury may involve the peripheral portion of one or both fourth nerves as they cross the tectum on the fascicular portion of one nerve where it ascends through the grey matter lateral to the aqueduct. Orbital trauma causing entrapment of superior oblique muscle or fracture of trochlea as a cause of palsy is very rare.

Technique of Examining IV Palsy

Classically the motility of the ocular muscles was tested in the cardinal directions of gaze by neurologists. Using this screening method unilateral and bilateral, fourth nerve palsies often go unrecognized. In our series the Bielschowsky head tilt test and the red glass test were used to make the diagnosis. The superior oblique muscle in the primary position function to intort and depress the globe. Palsy of superior oblique muscle causes vertical diplopia worse on downward gaze. Head tilting to the side opposite the palsy corrects the diplopia. Marked vertical diplopia will result when the head is tilted toward the shoulder of the paralyzed side (positive Bielschowsky sign). Trochlear palsy also may be detected by the red glass test, which consists of placing a red glass in front of one eye, determining the direction of the diplopia, finding the field of gaze which gives the widest separation of images, and determining the paralyzed muscle from the image that is projected farthest in the direction of gaze. These two tests can be combined and are especially helpful in diagnosing bilateral fourth nerve palsies since on one side the red image will be projected farthest, but when the head is tilted to the opposite side, the white image will be projected farthest.

Correlation of Duration with Etiology and Age of the Patient

Our findings are shown in Table 2.

All of the patients with unilateral fourth nerve palsy secondary to trauma resolved in 10 days to four months, regardless of their age. Of the two patients with bilateral fourth nerve palsy; one male age 30 resolved in seven months, the other male age 46, who was also a chronic alcoholic, did not recover fully. Trochlear nerve palsy secondary to

Table 2 — Fourth cranial nerve palsies, Wright and Hansotia — Etiology, age and duration

Etiology	Age (years)		Duration
Trauma	Unilateral	23 - 63	10 days - 4 months
	Bilateral	30 - 46	7 months, unresolved
Vascular		58 - 76	10 days - 3 months If unresolved after 3 months, persisted
Undetermined		53 - 65	1 day, others persisted
Other		7	Persisted (congenital)
		53	Persisted (postcraniotomy)
		65	2 months (associated with mesothelioma)

presumed vascular disease in our study resolved in 10 days to three months, or failed to resolve. Of the eight patients with vascular disease, five resolved, three persisted. Those that persisted were all males more than 60 years old. The cases of undetermined etiology were divided into one case which lasted one day in which there was no clinical evidence of history of migraine, and two cases which persisted. The patient whose episode lasted one day was a 53-year-old female. The two cases which persisted were 54 and 65-year-old males. The congenital fourth nerve palsy was found in a seven-year-old female. The post-craniotomy trochlear nerve palsy occurred in a 53-year-old female on the side opposite that which the aneurysm was clipped. The fourth nerve palsy associated with a mesothelioma of left side of chest occurred in a 65-year-old male and resolved in two months.

We conclude from our data that unilateral trochlear nerve palsies usually resolve in patients under age 60 within four months. Bilateral palsies are slower to resolve and may be permanent. Vascular-caused fourth nerve palsies usually resolve within three months; if they persisted longer, they were permanent (62.5% resolved, 37.5% persisted). Age was not a factor influencing prognosis on trochlear nerve palsies secondary to vascular disease. Those cases of undetermined etiology all occurred in patients over 50 years old and persisted, with the exception of the case which lasted one day and may have been atypical migraine episode. Our miscellaneous group was made up of patients over 50 years of age, with the exception of the patient with congenital fourth nerve palsy. In this group if the palsy persisted over two months, it was permanent.

From our experience the typical profile of a person with a fourth nerve palsy would be a male 20 to 50 years of age if secondary to trauma, or a male over 60 years of age if secondary to vascular disease who would recover in three to four months. For those who did not recover in four months, the trochlear palsy would be permanent.

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ABSTRACT WISCONSIN AUTHORS

The Coin Lesion Story: Update 1976

Twenty Years' Experience with Early Thoracotomy for 179 Suspected Malignant Coin Lesions

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Chest 70:332-336 (Sept) 1976

The case records of all patients who had undergone a thoracotomy for a coin lesion during the past 20 years were reviewed. The original diagnosis of a malignant neoplasm was histologically reverified in all instances. Additionally, patients with malignant coin lesions had follow-up evaluations. The rate of follow-up of the 27 patients with cancer was 100 percent.

Our definition of coin lesion is a radiologically detected, solitary pulmonary nodule less than 4 cm in diameter. Invariably such a lesion has been asymptomatic. Although we suggest 4 cm as the upper limit of size, the average coin lesion was much less than one-half that diameter. We believe that lesions over 4 cm are best called cancers from the onset, as that is so often the case. The largest coin lesion in this series was 3.5 cm in diameter.

There were 111 male patients (62%) and 68 female patients (38%). The average age of the 179 patients was 53 years. Twenty-seven patients (15%) had malignant coin lesions.

A total of 122 patients (68%) underwent limited thoracotomy, and 57 patients (32%) standard thoracotomy. There were 137 patients who had wedge resection, 25 underwent lobectomy, and 17 had miscellaneous operations including segmental resections, shelled-out hamartomas, excision of lymph nodes, and biopsy of pleural plaques.

No postoperative deaths occurred, but 14 patients (8%) had postoperative complications. Of these, 4 (2%) were major, and 10 (6%) minor.

The survival rate to the present of the 19 patients with primary lung cancer is 89 percent (17 of 19 patients). Of 12 cases of primary lung cancer followed for five years, 10 (83%) survived. Two patients died; one had a 2.7 cm anaplastic carcinoma and the other a 3.2 cm adenocarcinoma. The surviving patient with anaplastic carcinoma has been observed for 1.5 years only. The survival rate to the present of the eight patients with metastatic lung cancer is 25 percent (2 of 8 patients).

Duration of follow-up for the survivors with primary lung cancers includes: one patient over 15 years; seven patients 8 to 12 years; two patients 5 to 7 years; two patients, 4 years; three patients, 2 years; and two patients under 2 years. Thus, 59 percent (10) of the survivors have lived for five years or more, and 41 percent (7) less than five years.

It is our firm belief that early thoracotomy continues to be the clinically proven method of managing coin lesion with malignant potential. Neither radiologist, internist, nor surgeon is pleased with the present need for thoracotomy; but thoracotomy, for now, remains essential. The diagnostic accuracy is 100 percent, and effective therapy is provided simultaneously. ■

Infectious Mononucleosis: Seasonality in Wisconsin

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DURING THE MORE than 75 years that followed the initial description by Emil Pfeiffer,[1] infectious mononucleosis (IM) was generally considered to be a relatively inconsequential, nonfatal disease of the adolescent and college-age student. However, it did occasionally present problems in the differential diagnoses of other, more serious diseases and was recognized as being complex immunologically.

Since the incrimination of the Epstein-Barr (EB) virus as the causative agent of IM in 1968[2] and the development of agent-specific tests for antibody,[3] there has been an increased interest in all aspects of this disease. As a result, EB virus infections have recently been shown to be associated with such diverse conditions as pneumonia,[4] lymphopenia,[5] and encephalitis;[6] and high antibody titers to this virus have been shown to occur in patients with Burkitt's lymphoma, Hodgkin's disease, sarcoidosis, and systemic lupus erythematosus.[7] However, these associates may not be causal and suggest the need for further studies and surveillance of EB virus infections.

More importantly, EB virus has emerged as the leading contender for the role of the first viral agent identified as causing a malignancy, poorly differentiated nasopharyngeal carcinoma, in humans.[8]

During the past decades, IM was studied primarily in college students, a population group that may not reflect the entire natural history of this disease. Our seroepidemiologic studies,[9] and those of others,[10] have shown that in low socioeconomic groups, and under conditions of poor sanitation, EB virus infections occur with great frequency in younger age groups.

Unlike college-age populations, EB virus appears to be easily transmitted in younger age groups. It is not yet known whether the possible consequences of IM at college-age differ from those following exposure during early childhood. Nor are the possible risks associated with high antibody titers to EB virus fully understood. This latter question, and the possible role of EB virus infections in teratology and pregnancy wastage, are prospectively being explored at the State Laboratory of Hygiene.[11]

There is still considerable disagreement concerning seasonality of IM. Although Newell[12] reported peak incidence of IM in the summer and autumn, recent studies have shown an absence of consistent seasonal variation in a select population group, comprised of students in 19 United States colleges and universities,[13] as well as in a nationwide study based on 103,000 patient visits.[14]

The first community-based investigation of Henke and coworkers in Rochester, Minnesota[15] is of particular interest due to the geographic proximity of the study community to Wisconsin, and the meticulous diagnostic criteria employed. However, this study also failed to show a clear seasonal pattern, and peaks in IM cases were noted in only 14 of the 20 years studied. These peaks were distributed throughout the year and occurred on more than one occasion only in the months of February, April, July, and August.

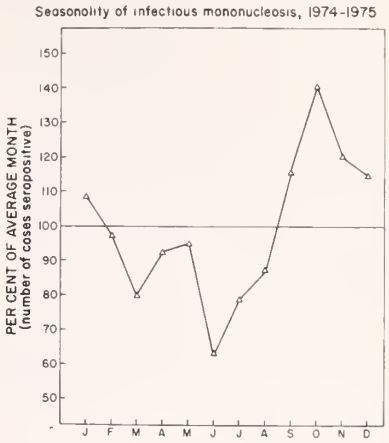

Figure 1

We have reviewed data, accumulated since the State Laboratory of Hygiene introduced the ox-cell hemolysin test for IM in 1974, on specimens routinely submitted from throughout Wisconsin for serodiagnosis of IM. As shown in Figure 1, the number of seropositive specimens was markedly elevated from September through January in 1974 and 1975, with peak incidence in October. The number of seropositive sera was lowest in March and in June.

Preliminary data from 1976 have shown no change from the seasonal pattern for the preceding two years in Wisconsin. It is possible that the differences between our findings in Wisconsin and the above studies are due to the dissimilarities in the age groups studied, the combining of data from various geographic regions, and the divergencies in the diagnostic criteria employed.

It is of interest to note that the serodiagnostic detection rate was lowest in Wisconsin during the months of March and April; while the number of specimens submitted during these months for IM serology was above average, the number of samples found to be positive was clearly below average during these two months. This pattern suggests the presence of some other agent(s), capable of producing IM-like illness, during these months.

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This result is supported by the finding that equivocal diagnostic cases increased in late winter and in spring in Rochester, Minnesota.[15]

In order to explore the role of additional IM syndrome agents, a serologic study concerning the incidence and seasonality of infections with *Toxoplasma gondii,* cytomegalovirus, herpes simplex virus, adenovirus, and Group A hemolytic streptococcus was initiated at the State Laboratory of Hygiene. This second study will be completed shortly.

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ABSTRACTS WISCONSIN AUTHORS

Immunotherapy and Chemotherapy of Gynecologic Cancers

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Am J Obstet Gynecol 124:808-817 (Apr) 1976

Recurrent cervical, ovarian, and breast cancers have been treated with immunochemotherapy. Optimum chemotherapeutic agents have been determined by direct and indirect methods of sensitivity determination. The Hellstrom assay has been used for lymphocyte-tumor recognition and for cytotoxicity assays. Vaccines developed in this laboratory, consisting of autologous and allogeneic tumor-associated antigens, combined with BCG, have been used in immunotherapy.

Objective tumor regression and notable clinical improvements have been observed. Forty-five advanced cases, including recurrent cancers of the cervix and ovary, along with sarcomas, breast malignancies, and melanomas, have been treated: 16 patients have died of their disease and 29 patients have survived for 6 months to 1½ years. Some of these have shown either regression, total disappearance, or stabilization of their disease process.

While the results of these preliminary studies are encouraging, the as yet unknown potential of this modality cannot be expected until it is applied earlier, at a time when residual tumor cells are minimal. ■

Further Clinical Studies with Megestrol Acetate in Advanced Breast Cancer

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Cancer 38:53-55 (July) 1976

Of 101 patients treated with megestrol acetate (Megace) 26 percent met our criteria of improvement. It was most effective in skin or soft tissue lesions and especially in the older women, although excellent responses were observed in all postmenopausal age groups and in visceral and osseous metastases as well.

Prior hormonal or cytotoxic compounds did not appear to reduce the subsequent responsiveness to this potent progestational compound. It produced no toxicity and had the additional advantage over sex hormones in that no undesirable endocrine effects were observed. It appeared to have anabolic activity and produced weight gain (not fluid retention) in most patients.

Because of its promising response rate and freedom from undesirable reactions some of our group now use Megace 40 mg after each meal and at bedtime as the initial steroid trial in disseminated breast cancer. ■

Current Status of the Radioactive ^{131}I Uptake Test

Effects of Gelatin Capsules and Dietary Iodine

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Minn Med 59:530-535 (Aug) 1976

There was no difference in the uptake of radioactive ^{131}I by the thyroid of subjects administered ^{131}I orally in gelatin capsule and liquid form. The uptake of ^{131}I by the thyroid 24 hours after oral administration (U_{24}) was significantly reduced in our subjects when compared to normal measurements of 10 to 15 years ago. Elevated urinary excretion of iodine by subjects and alterations of iodine kinetic studies suggest a relatively high intake of dietary iodine. Chemical analysis of hospital and nursing home diets revealed high iodine content. However, drinking water, commercial bread, milk, and a widely used emulsifying agent did not contain large amounts of iodine. Physiologic adaptation ("autoregulation") lowers thyroid uptake during periods of high iodine intake. Although the U_{24} remains a useful adjunct for the diagnosis of Grave's disease, the test is no longer suitable for the diagnosis of hypothyroidism. Diminished thyroid uptake may also interfere with ^{131}I therapy for thyroid cancer and hyperthyroidism and increased dietary iodide may diminish the remission rate of hyperthyroidism after antithyroid drug treatment. Current levels of dietary iodine are safe, but further increases may result in thyroid dysfunction in predisposed patients. ■

The Evaluation of Medical Care in Patients with 25 or More Office Visits Per Annum in a Prepaid Plan

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• The records of 116 of 130 patients with 25 or more documented outpatient encounters in 1974 were analyzed. They were members of the Greater Marshfield Community Health Plan. The most common clinical entities were malignancy, speech problems, lumbosacral distress, multiple individual diagnoses, and allergic diseases with desensitization procedures. There were six patients in whom it was considered that either the provider or the frequency of visits was inappropriate. It is concluded that in 1974 the majority of clinical conditions requiring repeated office visits, the frequency, and the providers were appropriate. It is hoped this report will encourage analysis of high encounter rates to review the clinical diagnosis and its relationship to the appropriateness of the frequency of the visits and provider of the services.

THE INCREASING interest in numbers and types of prepaid group practice has stimulated medical care utilization studies. The principal focus, however, has been on inpatient and outpatient care, before and after enrollment in such a plan.[1-5] Utilization patterns by enrollees in the Greater Marshfield Community Health Plan have been studied in this way.[6] This paper reports an analysis of patients enrolled in the Greater Marshfield Community Health Plan who have had 25 or more office visits during the year 1974, to determine whether the clinical condition or disease, the frequency of visits, and the type of provider were appropriate.

Table 1—Clinical conditions or diseases in patients with 25 or more encounters — GMCHP — 1974

Malignancy	23
Speech Problems	21
Lumbosacral Distress	10
Multiple Diagnoses	10
Allergy/Asthma	9
Orthopedic Surgery	8
Psychiatric	6
Diabetes	5
Rheumatoid Arthritis	5
Cardiovascular Disease	4
Injury	3
Oral Surgery	3
Neurological	3
Recurrent Infection	2
Pulmonary	1
Eye Problems	1
Vein Surgery	1
Dermatological	1
TOTAL	116

GMCHP=Greater Marshfield Community Health Plan

Materials and Methods

The Greater Marshfield Community Health Plan was started in March 1971 as an alternative prepaid health-care system by a multispecialty clinic group in Central Wisconsin.[5-9] Data on inpatient and outpatient utilization was available through the computer section of the Marshfield Clinic. The account numbers of all patients in 1974 with 25 or more office visits were identified. This represented 130 enrollees out of a total of 17,343, an average of 0.7% for the year. The Clinic registration number was determined from the Greater Marshfield Community Health Plan account number. The records were reviewed and the following data retrieved: (1) The principal condition for which the 25 or more visits occurred. (2) An assessment was made to determine whether the frequency of visits was appropriate. (3) The appropriateness of the provider [whether internist, subspecialist—such as oncologist, physiatrist—auxiliary personnel—such as speech therapist, physical therapist] was determined.

Results

One hundred and sixteen (116) out of 130 charts were included in the evaluation. The data recorded (for the remaining 14) was not adequate to make judgments. Table 1 lists the major diagnosis or clinical problem producing the 25 or more encounters in these patients. There were six patients in which it was felt that the frequency or the provider was inappropriate. In four the diagnosis was adequate but the frequency of office visits was inappropriate. In two it was concluded that the patient had undiagnosed depression and should have been seen by a psychiatrist.

Discussion

Most utilization studies do not include the specific evaluation by clinical entity of extremely frequent outpatient users. In this study directed toward patients who paid for the medical care by the month and had no barriers to care, the most common clinical entity was malignancy. The repeated office visits usually constituted outpatient chemotherapy injections. The second most common clinical entity in this group of patients was children with speech problems, who were seen several times a week for speech therapy. Patients with multiple diagnoses and patients with significant lumbosacral distress were the next most common. There was usu-

From the Marshfield Clinic and Marshfield Medical Foundation, Inc, Marshfield, Wisconsin.
Doctor Lohrenz, who died August 11, 1976, was a member, Department of Endocrinology, Marshfield Clinic and Marshfield Medical Foundation, Inc. Mr Nycz is a research biostatistician, Mr Wenzel is executive director, and Ms Jacoby is a health accountant, Marshfield Medical Foundation, Inc.
Supported in part by a grant from the Wisconsin Regional Medical Program.
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ally no particular difficulty in identifying the principal diagnosis or clinical problem.

In some the repeated office visits involved providers other than a physician. In the group of nine patients diagnosed allergy or asthma, the initial visit was with the appropriate provider—an allergist—and subsequent visits were for desensitization procedures. In certain musculoskeletal conditions, such as rheumatoid arthritis or those with lumbosacral stress, a major portion of the outpatient encounters was for appropriate physical therapy visits.

It is of significance that the clinical condition diagnosed inappropriately was depression, manifesting itself mainly by psychosomatic complaints. Depression was diagnosed in four patients. The patients were seen by providers other than psychiatrists, and there was no evidence that antidepressant drugs were being administered. In the opinion of the authors two patients with chronic lumbosacral distress were seen too frequently. Outside providers of primary care for the Plan administered manipulation to the patients rather than more common physical therapy measures for lumbosacral distress.

It was not possible at this time to accumulate a cohort group of age and sex-matched patients in the fee-for-service population, with a similar number of outpatient encounters. This analysis included only patients who were members of the Greater Marshfield Community Health Plan.

This study suggests that the care given to patients with over 25 encounters per year was appropriate, for the most part. A similar study should be conducted in those patients with less than 25 encounters per annum, which would constitute a much greater percentage of the total seen.

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ABSTRACTS WISCONSIN AUTHORS

Severe Aplastic Anemia: A Prospective Study of the Effective Early Marrow Transplantation on Acute Mortality

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A multi-institution prospective randomized study compared different treatments for severe aplastic anemia. Severity was defined as two or more peripheral blood criteria (PMN<500/mm^3, platelets < 20,000/mm^3, singly corrected reticulocytes < 1.0%) *and* a bone marrow either severely hypocellular (>25% of normal) or moderately hypocellular (25-50% of normal with >70% nonhematopoietic cells).

Following diagnosis a three-week observation period allowed time for spontaneous marrow improvement, for histocompatibility typing, and for detecting underlying disease. During this interval transfusions were minimized and when necessary, only unrelated donors were used. At three weeks all unimproved patients with histocompatible (HLA-MLC identical) sibling donors were scheduled to receive marrow transplants. Transplantation was performed a median of 33 days after initial diagnosis. Patients without donors were randomized to medical regimens including No, IM, or PO androgens.

Twenty-four of 36 transplanted patients were alive with full hematopoietic reconstitution. In contrast only 12 of 31 conventionally treated patients survived (and half of these survivors were unimproved hematologically). There were no differences among the nontransplant randomizations but this aspect of the study requires further study.

Pending longer followup of survivors, *early* use of histocompatible marrow transplantation appears to be the most effective available treatment for severe aplastic anemia. Alternative therapies are needed for nontransplantable patients. ■

Angiosarcoma of the Liver in a Rural Population

Four Cases Diagnosed in a 29-Month Period

JUSTUS J FIECHTNER, MD and CESAR N REYES JR, MD, Marshfield Clinic and Medical Foundation and St Joseph's Hospital, Marshfield, Wis: *JAMA* 236:1704-1706 (Oct 11) 1976

Angiosarcoma of the liver has been publicized recently because of its association with polyvinylchloride (PVC) polymerization workers. Four cases of this rare tumor have been observed at the Marshfield Clinic within a 29-month period. All four patients were Wisconsin residents and had farm labor histories. There are no factories that manufacture PVC products in Central Wisconsin nor were any of the victims ever involved in such manufacturing work; thus, it is possible that other factors may be related to this particular cluster of the disease. ■

Monitoring Heparin Therapy

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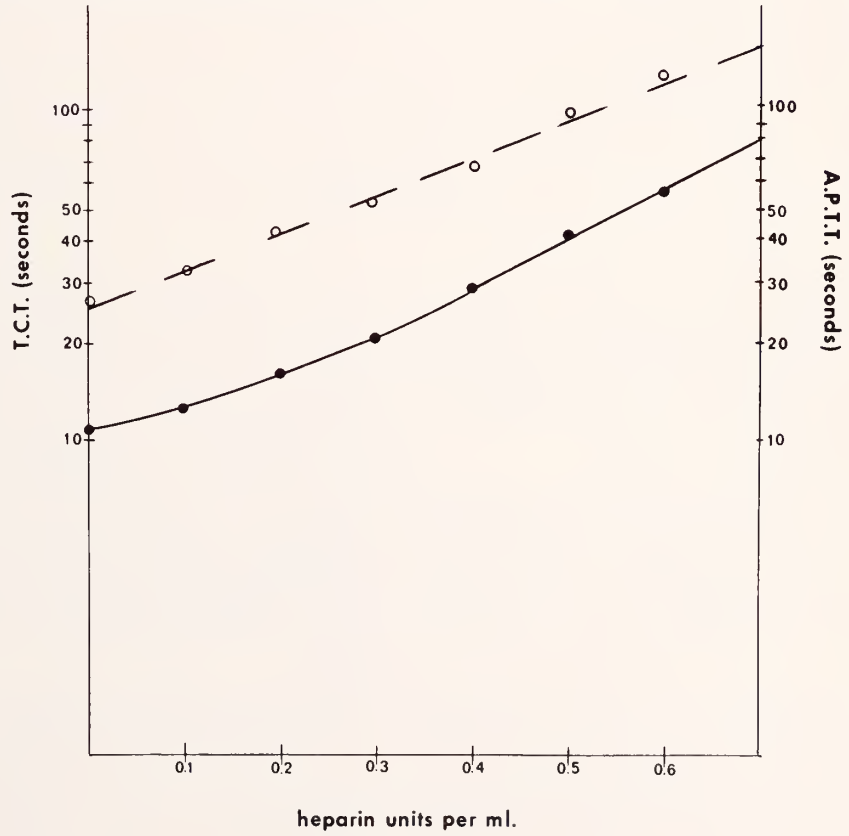
HEPARIN IS a sulfated, negatively charged mucopolysaccharide with a molecular weight of 3000-37,500.[1] The mean circulating half-life of heparin is approximately one hour, but individual values vary greatly.[2] Heparin is catabolized by the liver and reticuloendothelial system and excreted in the urine. Heparin is a potent anticoagulant in the presence of a plasma cofactor, an alpha 2 globulin similar to antithrombin III.[3] Heparin combined with the plasma cofactor exerts a progressive, irreversible inhibition of activated clotting factors, including factors XII_a, XI_a, X_a, and II_a (thrombin).[4,5] Most laboratory methods for the assay of heparin are based upon the anticoagulant effect.

Clinical use of heparin for treatment of thrombotic and thromboembolic disorders could be enhanced by improvement of laboratory methods used to monitor heparin therapy. This report deals with three laboratory procedures currently used to monitor heparin therapy: (1) the Lee-White Clotting Time (CT),[6] (2) the Activated Partial Thromboplastin Time (APTT),[7,8] and (3) the Thrombin Clotting Time (TCT).[9] The CT is most popular despite serious limitations related to lack of reproducability, prolonged observation periods required, and the difficulties of standardization (*i.e.*, temperature control, surface contact, and endpoint). The APTT though more sensitive to heparin levels within the critical range (0.2-0.4 heparin units per ml) is subject to the influence of deficiencies of the plasma procoagulants. The TCT provides greater reproducability, greater sen-

Figure 1—Mean clotting times were plotted semilogarithmically against heparin concentrations. o—o activated partial thromboplastin time (APTT). ●—● thrombin clotting time (TCT).



From the Department of Laboratory Medicine, Trinity Memorial Hospital, Cudahy, Wisconsin.

Publication support by the above.

Mr Stevens is a Medical Technologist, Hematology Section, and Doctor Latorraca is Director of Laboratory Medicine.

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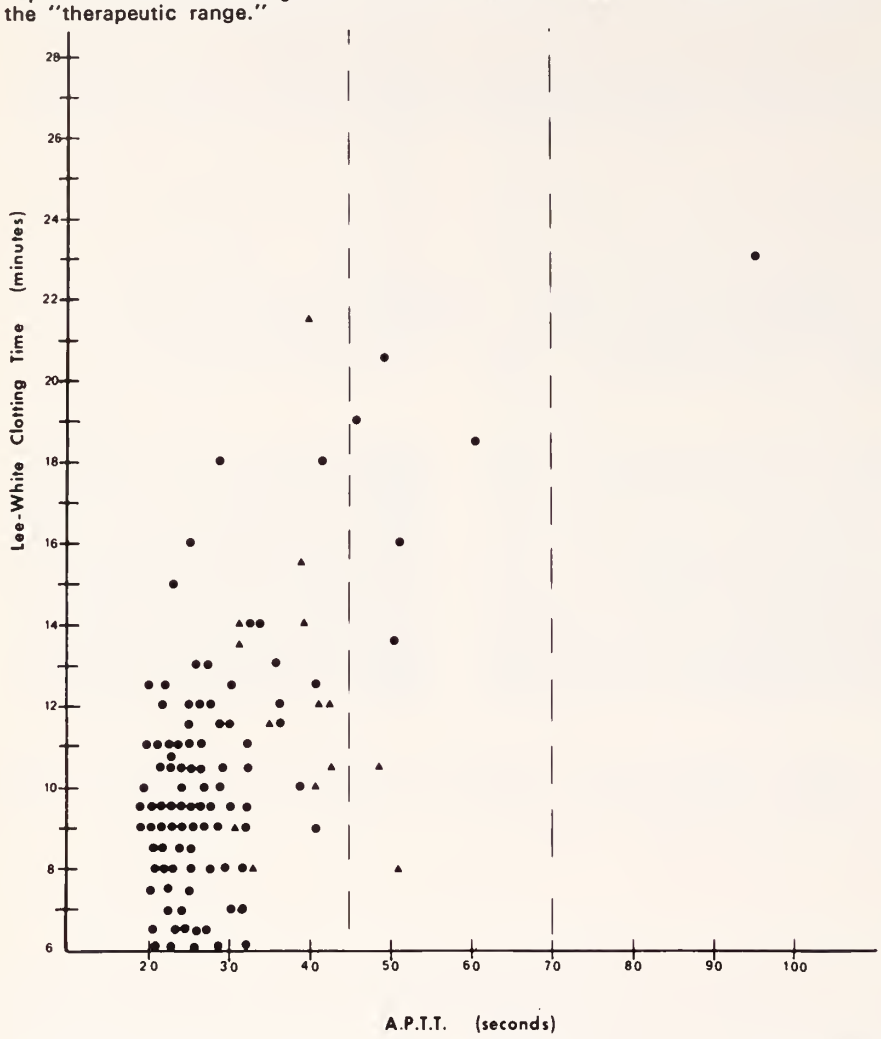
Figure 2—Lee-White clotting time versus the activated partial thromboplastin time (APTT). The patients designated with an ▲ are those receiving both heparin and oral anticoagulants. The area between 45-70 seconds represents the "therapeutic range."



sitivity (heparin levels down to 0.005 units per ml),[10] and is not influenced by plasma procoagulant deficiencies with the exception of fibrinogen.

Methods and Materials

Whole blood specimens were obtained from normal volunteers by clean, nontraumatic venipuncture. These samples were then divided, three milliliters for the Lee-White and the rest mixed in a ratio of nine parts whole blood to one part 3.8% sodium citrate. In preparing the citrated specimens for use in the APTT and the TCT, the sample was centrifuged for 10 minutes at 2000 x g within 15 minutes of venipuncture, the resulting plasma was platelet poor. For known heparin concentration studies, various dilutions of heparin were mixed with platelet-poor plasma from normal donors.

The automated APTT assay[7] used involves platelet-poor plasma, 0.1 ml incubated for three minutes at 37 C with 0.1 ml of a partial thromboplastin.* At the completion of incubation, 0.1 ml of a calcium chloride solution was added and the clotting time recorded.† The Lee-White clotting assay[6] was performed at 37 C using three disposable dry glass tubes for each assay, the clotting time of the third tube was the value reported. The Thrombin Clotting Time assay was performed within 30 minutes of venipuncture. Human thrombin, purchased from a commercial source,‡ was diluted in accordance with the method of Penner.[9,11] Platelet-poor plasma, 0.2 ml, was incubated at 37 C for a minimum of three minutes at which time 0.1 ml of a dilute thrombin-calcium solution was added and the endpoint determined using a mechanical device.†

Results

The APTT and the TCT were employed to measure heparin concentrations in a series of heparin treated, pooled, platelet-poor plasma obtained from normal volunteers. Mean clotting times were plotted semi-logarithmically against heparin concentrations (Fig 1). The heparin concentrations ranged from 0.1 to 0.6 heparin units per ml, concentrations of greater than 0.6 heparin units per ml were measurable, but with very poor reproducability. Dilution of samples containing excess heparin, with 0.9% saline or fresh normal platelet-poor plasma, permitted accurate determination of the heparin activity. Heparin levels greater than 0.6 heparin units per ml would rarely be encountered in routine monitoring of heparin therapy.

A comparative study was done on plasma from 130 patients receiving heparin therapy for various thrombotic or thromboembolic disorders. A comparison between the CT, the APTT and the TCT can be seen in Figures 2, 3, and 4. There appears to be poor correlation between the CT and either the APTT (Fig 2) or the TCT (Fig 3). However, there is correlation between the APTT and the TCT (Fig 4).

Discussion

The amount of heparin given to an individual patient should be sufficient to prevent thrombus forma-

Sodium Heparin, Upjohn Co., Kalamazoo, Michigan.

‡Fibrindex Reagent, Ortho Diagnostics Inc, Raritan, NJ. Lot # 8N 213.

*Activated Thrombofax, Ortho Diagnostics Inc, Raritan, NJ.

†Fibrometer, Becton, Dickenson Co., Cockeysville, Maryland.

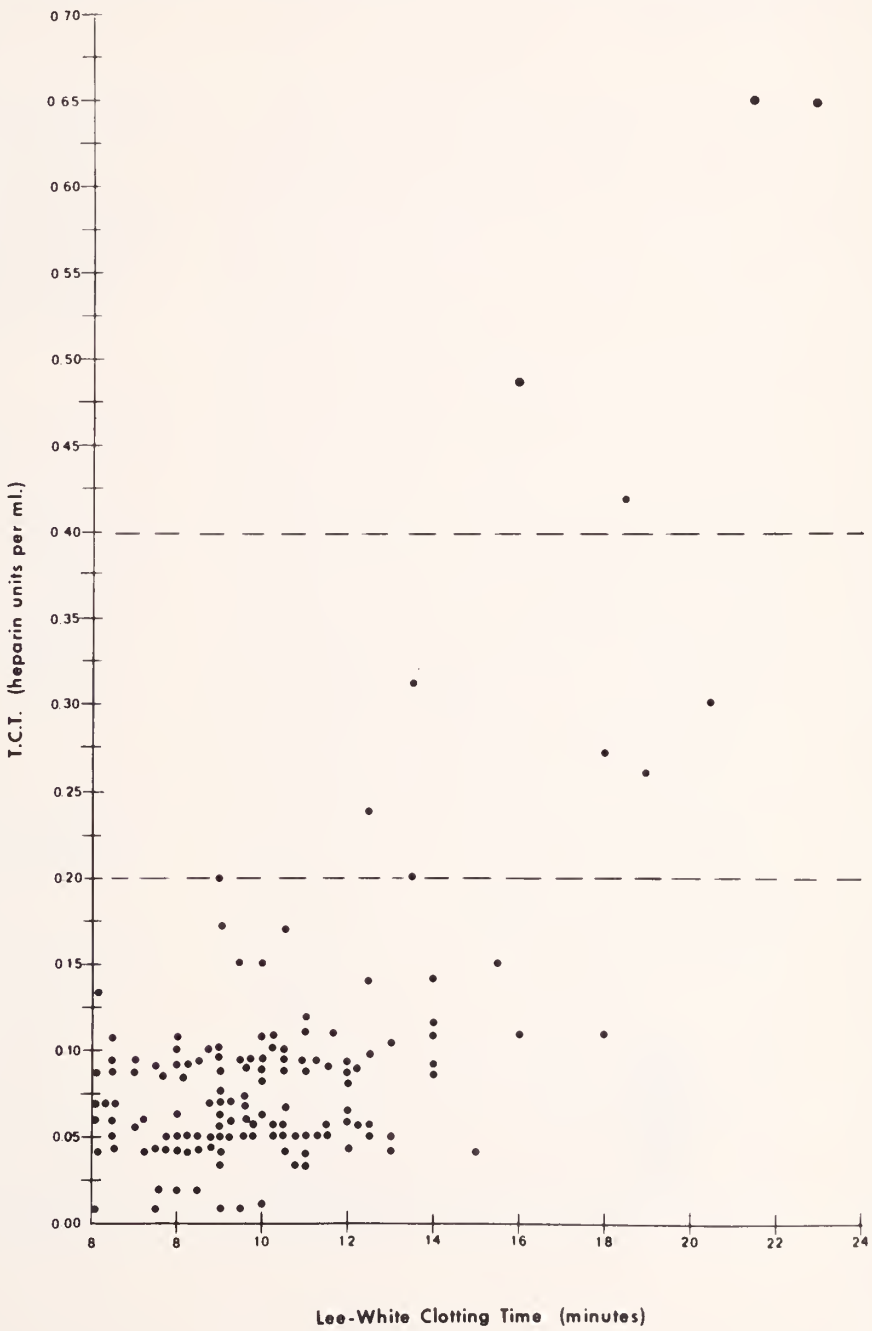
tion or extension, but should not result in a concentration great enough to induce hemorrhagic complications. At present, no practical laboratory procedure is available that accurately measures the in vivo interaction of thrombin and circulating fibrinogen. Laboratory methods used to monitor heparin therapy rely solely upon the anticoagulant effect of the circulating heparin. In order to effectively evaluate heparin therapy, a laboratory procedure must be useful at high and low levels of circulating heparin, it must be reproducable and easy to perform under controlled laboratory conditions.

In comparing the CT, APTT, and the TCT it is apparent that the CT is the least satisfactory means of monitoring heparin therapy. The CT assay has serious limitations in reproducability and is generally cumbersome. Values obtained with the CT assay do not correlate well with the APTT assay or the TCT assay. The CT procedure is influenced by many variables which affect the endpoint.

Values obtained with the APTT assay correlate well with those obtained with the TCT assay and is reported to be accurate at a wider range of heparin levels.[8] However, there is a problem of its specificity. Prolongation of the clotting time, measured by the APTT assay may be due to either circulating heparin or deficiencies of plasma procoagulants. The generally accepted regimen for treatment of thrombotic or thromboembolic disorders is a 3-5 day overlap of heparin therapy and oral anticoagulant therapy. This would result in a depression of clotting factors II, VII, IX, and X, thereby, influencing the APTT assay result. With therapy overlap it is impossible, using the APTT, to determine whether the prolonged clotting time is due to circulating heparin or to multiple factor deficiencies. This inability to separate effects might prompt a physician to decrease the heparin, with a resulting increase in the risk of thrombus extension.

The TCT assay as described by Penner[9] appears to be as sensitive a measurement of heparin as the APTT assay (Fig 4) with less influence exerted by deficiencies of the plasma procoagulants. In the comparative studies the patients with prolonged clotting times, measured by the APTT assay and with a TCT value indicating less than therapeutic levels of heparin, were patients receiving both heparin and oral anticoagulants. Plasma prothrombin times of these patients were between 1.5 and 2.5 times that of the normal control. The foremost advantage of the TCT assay is that the only plasma constituents meas-

Figure 3—Lee-White clotting time versus thrombin clotting times. The area between 0.2-0.4 heparin units per ml represents the "therapeutic range" for the thrombin clotting time (TCT).



ured are fibrinogen and circulating heparin.

The implications of these data are that any method for measurement of circulating heparin must measure only the anticoagulant effect of heparin and must be sensitive to both high and low levels of heparin. The TCT assay seems to fulfill these requirements and, in addition, it is easily controlled and has a high degree of reproducability.

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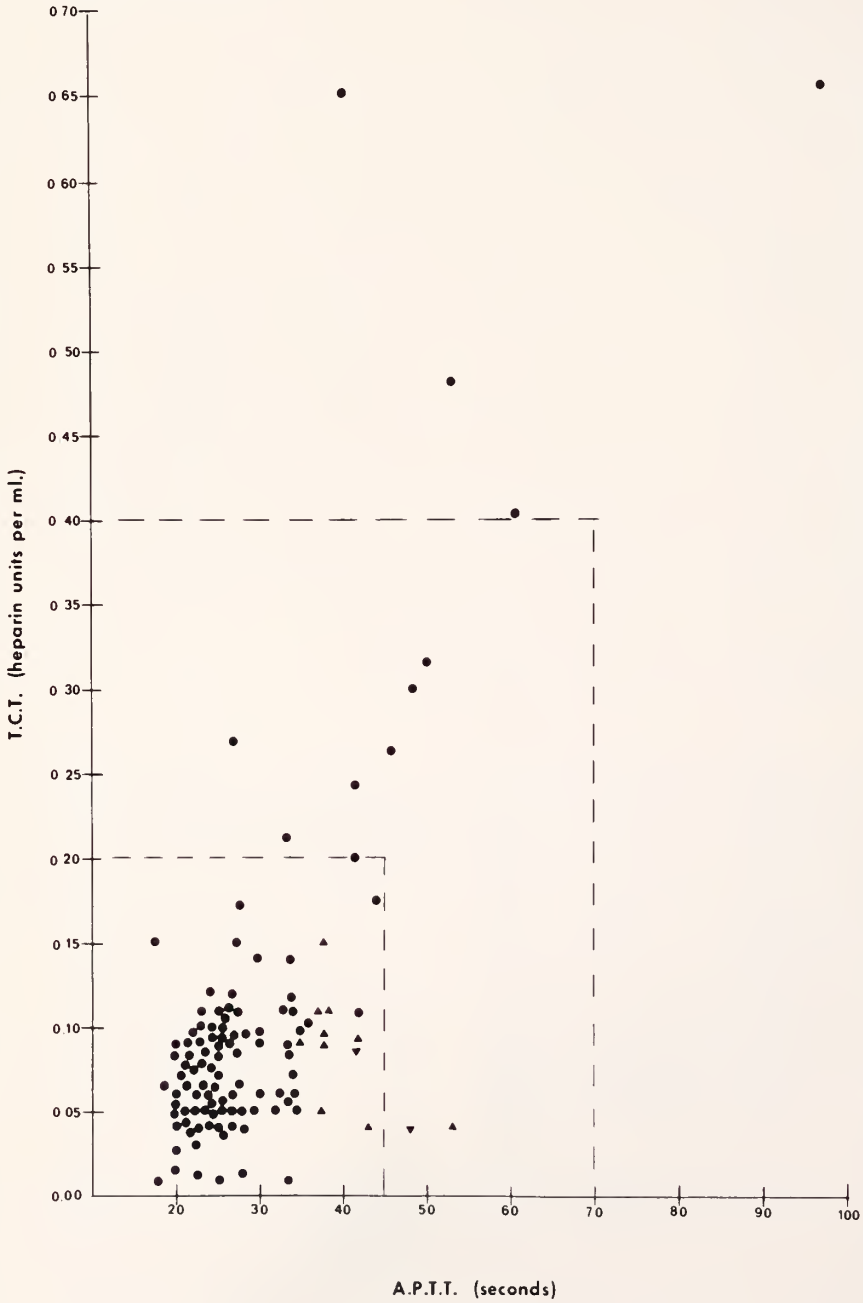
Figure 4—The activated partial thromboplastin time (APTT) versus the thrombin clotting time (TCT). The patients designated with a ▲ are those receiving heparin and oral anticoagulants. These patients had prothrombin times between 1.5 and 2.5 times the normal control. The area between 0.2 and 0.4 heparin units per ml for the TCT and 45-70 seconds for the APTT represents the "therapeutic range."



Visual Loss After Cardiopulmonary Bypass

PHILIP J TAUGHER, MD, Hales Corners, Wis: *Am J Ophthalmol* 81:280-288 (Mar) 1976

Neurological complications following cardiopulmonary bypass are well known but vision loss has not been emphasized. In this report ten cases of vision loss following cardiopulmonary bypass are presented. All occurred during the period from January 1 through December 31, 1974. Nine cases occurred at one facility and one at another. The degree of vision loss ranged from total permanent blindness (one case) to several episodes of transient ischemic attacks (one case). Three had homonymous hemianopia, three had paracentral scotomata and four had central scotomata. In all cases the eye findings were normal. Brain scan studies demonstrated that the loss of vision was due to varying degrees of occipital cortical necrosis. The exact mechanism by which the damage took place is not known. Thrombosis, embolization, and selective cortical laminar necrosis are discussed as possible causes.

When a patient who has recently undergone cardiopulmonary bypass complains of visual symptoms, he should be examined by an ophthalmologist and visual fields should be done. ■

SPECIAL TO THE JOURNAL

Guillain-Barré Syndrome

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Madison, Wisconsin

THE OCCURRENCE of the Guillain-Barré syndrome in patients previously inoculated with swine influenza vaccine renewed interest in this condition. The Department of Neurology Grand Rounds at the University of Wisconsin-Madison, on January 9, 1977 dealt with the problems of the Guillain-Barré syndrome and its possible relationship with the swine flu vaccine. Four patients were reviewed.

There are many synonyms for this condition. The eponymic synonyms are Landry's paralysis, Guillain-Barré-Strohl's syndrome and Landry-Guillain-Barré syndrome. Other names attempting to be descriptive rather than eponymic are acute infectious polyneuritis, acute febrile polyneuritis, polyneuritis with facial diplegia, post-infectious polyneuritis and acute inflammatory polyradiculopathy. The variations in these descriptive names indicate variation in the clinical condition as well.

CLINICAL MANIFESTATIONS

Clinically the syndrome consists of a subacute paralytic process involving primarily the peripheral and only secondarily the central nervous systems.

In approximately half of the patients an acute infectious illness occurred one to three weeks prior to the onset of symptoms. The infectious episodes had usually cleared completely before the onset of paralysis.

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The initial complaint is bilateral weakness usually in the lower extremities. This is symmetrical and the patient complains first of difficulty in walking and then the weakness becomes more severe and more extensive. Although this weakness starts peripherally, it often is most marked proximally, for example in the pelvic girdle muscles. Occasionally the onset is weakness in the upper extremities but this is unusual. The paralysis continues to extend and cranial nerve involvement occurs in about half of the patients. The most common cranial nerve involved is the facial and this is bilateral. External ophthalmoplegias occur in about 10% of the cases. With the lower cranial nerve involvement there occurs difficulty in swallowing, speaking, and, most important, respiration.

The deep tendon reflexes are decreased and later absent. The pattern of the deep tendon reflex changes follows that of the paresis. The rate of spread of the paralysis varies greatly. Total paralysis including respiratory involvement may occur within a few hours, but normally the process requires more than 72 hours. The paralysis reaches its peak within two weeks in 50% of the patients, in three weeks in more than 80%, and after four weeks is complete in at least 90% of the cases. Once the high tide of paralysis has been reached, there follows a short period of stability in the clinical condition and then recovery begins.

Sensory symptoms are as a rule much milder than motor manifestation. They can be the presenting complaint but are characteristically milder and out of proportion to the changes in the involved nerves. No case has been recorded of purely sensory involvement. Vibratory and position sense are most frequently involved with light touch impairment the next frequent

and least change in pinprick and temperature. Light touch, pinprick, and temperature changes when present are often in a glove-stocking pattern. Significant pain is present in less than one-third of the patients.

The autonomic nervous system also may be involved and this carries with it serious implication for the management of the patient. Sinus tachycardia and inverted T-waves have been reported in approximately one-half of the patients and these may be due to autonomic nervous system involvement. Orthostatic hypotension can occur because of the decrease in peripheral vascular tone and may lead to low output circulatory failure. The hypotension may be triggered by mild dehydration.

Hypertension lasting from days to several weeks is almost as frequent as hypotension. This may be due to abnormal sensitivity to normal levels of pressoramines. Loss of sweating is often present, but in some patients increased sweating with vasoconstriction is occasionally seen, probably reflecting a loss of proper thermal regulation. The presence of a Horner's syndrome is an occasional occurrence. Overactivity of the parasympathetic system can result in episodes of facial flushing, bradycardia, extreme generalized warmth, profound weakness and a sensation of "tightening" in the chest and abdomen. These episodes seldom last longer than 30 minutes and are followed by deep sleep. The symptom complex can be provoked by Valsalva maneuvers and edrophonium (Tensilon®).

LABORATORY FINDINGS

The white blood cell count in the spinal fluid is usually normal at 0 to 5 cells. Occasionally there may be a slight increase but seldom more than 20 lymphocytes may occur. The normal blood cell count coupled with the increased total protein in the spinal fluid constitute the "dissociation albuminocytologique." Initially the spinal fluid protein may be elevated or normal. As the clinical picture progresses CSF protein continues to rise with peak values occurring around four to six weeks after the onset of symptoms. The CSF protein levels are then between 100 and 200 mg per 100 ml, although levels up to 2 gm per 100 ml have been reported. The protein levels may continue to rise after the onset of recovery. The relative protein pattern is usually described as normal although a relative increase in IgA early in the course has been found.

In the blood cell counts a mild polymorphonuclear leukocytosis with a slight change in immature direction occurs. There are elevated immunoglobulins, with complement fixating antibodies to myelin, present in the majority of cases studied. IgM and complement have been found bound directly to peripheral nerve-myelin, especially late in the disease.

A relatively specific effect in this syndrome seems to be the in vitro activation of the patient's lymphocytes by peripheral nervous tissue. The effect has been reproduced with four different methods in five laboratories.

EMG: Slowing of nerve conduction is characteristic and is present in 86% of patients examined in the first three weeks of the disease. The conduction velocity may continue to slow down after the onset of recovery, and moderate slowing is frequent even in clinically fully recovered cases. Signs of denervation usually are not present.

PROGNOSIS

This syndrome was originally reported as a relatively benign condition. As time went on, significant mortality rates became apparent. Some 30 years ago mortality rates were 40% or higher. The development of modern techniques of respiratory therapy led to a sharp drop in the mortality rates so they are now approximately 10% of the acute cases. The recovery time ranges from several weeks to months and 85% of the patients recover completely after four to six months. A few patients may require more than a year for full recovery.

Recovery is usually complete without clinical deficits. However, asymptomatic, but demonstrable, mild impairment of vibratory and position sense in the lower extremities may occur. Occasionally permanent motor deficits have been reported usually not severe enough to be symptomatic. Relapses of the syndrome occur in about 3% of the cases and about half of these patients have more than one relapse. Recovery tends to be less complete after each episode.

The occurrence of chronic forms of the syndrome has been reported and undoubtedly exists, but the differential diagnosis then is complex between diseases such as Refsum's and the hypertrophic neuropathy of Dejerinne-Sotta.

PATHOLOGY

The characteristic microscopic finding is segmental demyelination with a variable degree of monocytic infiltration. Studies in recent years indicate, contrary to earlier beliefs, that all parts of the peripheral neuraxis are involved and not primarily the nerve roots. The lesions are scattered and degeneration can be found adjacent to an area of regeneration. In the most severe cases axonal degeneration of the Wallerian type can be found.

Spinal cord changes with nucleolysis and retrograde necrosis are invariably secondary to the changes in the peripheral nerves.

The primary pathologic lesion is in the Schwann-cell and the myelin sheath, and it is the same irrespective of the etiology. This underlines that the nervous system can respond pathologically only in a limited number of ways to unrelated noxae.

The demyelinization is followed by the activity of macrophages lying between the Schwann-cell proper and the innermost layer of myelin. The exact mechanism involved is unknown although a number of theories exists. During regeneration, one Schwann-cell is replaced by several new ones and the resulting myelin sheath is always thinner than the original. This is the reason why nerve conduction frequently is slower after restitution than before the onset of paresis, and it does not necessarily indicate a chronic ongoing process.

ETIOLOGY

The Guillain-Barré syndrome, therefore, consists of a quite specific clinical picture with a rather consistent laboratory profile and a reasonably predictable outcome. Because of the multiple etiologies, therefore, this is a syndrome rather than a disease.

The syndrome occurs in metabolic disorders such as porphyria; and indeed this should be suspected as a cause, especially in patients with relapses or secondary occurrences. The syndrome can occur in toxic conditions as lead or arsenic poisoning. It also may occur in pregnancy and after surgical procedures, without an infectious or inflammatory process occurring, and is not dependent upon the type of surgical procedure or kind of anesthesia.

Other factors: It has been reported in association with malignant disease, especially Hodgkin's and others affecting the lymphatic system. It is found more often in persons with a history of alcoholism with associated liver impairment.

However, since many of the patients have had a preceding febrile illness, infectious etiologic factors, especially viral, are usually suspected as the cause. However, scarlet fever and pulmonary infections due to *Mycoplasma pneumoniae* have preceded cases of the syndrome.

Association with a variety of viral diseases has been well documented including influenza types A and B, measles, mumps, rubella, varicella, and the diseases due to the herpes zoster and cytomegaloviruses. These viruses are at least in part neurotropic, possess a viral envelope and incorporate the host-membrane in their coating. An exception to this is the known association with hepatitis-virus, which is not enveloped. Reports of association with ECHO-virus are not firmly documented at present. A definite association has been shown with cases of infectious mononucleosis.

The syndrome also may occur after immunizations. The connection is strongest with rabies vaccination, especially with the old vaccine prepared from the spinal cord of infected rabbits. The incidence after rabies immunization has decreased significantly with the introduction of the attenuated virus vaccine. Other immunizations which produced this syndrome include typhoid and the experimental vaccine against multiple sclerosis produced by Margoulis and Choubladze. Vaccinia-immunization also has been implicated, and it is of interest that this syndrome normally follows revaccination, whereas post-vaccination encephalomyelitis occurs only after the primary vaccination.

The occurrence of the syndrome after an infectious disease or immunizations and with a delay of several weeks, the changes in immunoglobulins noted, and the occasional occurrence with diseases of the lymphoid system all suggest an autoimmune process. The recent occurrence of the disease after the administration of influenza vaccine raises the question of possible relationship between swine flu vaccination and Guillain-Barré.

CASE PRESENTATIONS

Case 1. An 80-year-old female housewife was inoculated with the swine flu vaccine in the last

week of October 1976. On November 26 she noted fatigue and backache followed by weakness of her legs. Three days later she had some episodes of postural hypotension. The weakness progressed and on December 6 there was marked weakness of the legs, with virtual paralysis. All deep tendon reflexes were absent. On December 12 weakness began in the upper extremities. Lumbar puncture on December 21 revealed normal pressure, no cells, and total protein of 58. Electromyographic studies demonstrated evidence of motor and sensory neuropathy. There was a short period of bulbar involvement lasting four days after which there was gradual recovery.

Case 2. A 24-year-old male farmer received the swine flue vaccine on December 12, 1976. Ten to 15 days later he became aware of backache and numbness particularly in his hands and feet. On December 29, 1976 weakness began and this became progressively worse. On admission (December 31) he had generalized weakness including bilateral facial paralysis. The deep tendon reflexes were absent and sensation was decreased in the upper and lower extremities. Gait was extremely unstable because of the weakness.

Examination of the cerebrospinal fluid revealed no cells and a total protein of 291 mg per 100 ml. The patient's pulmonary functions and arterial blood gases were within normal limits. However, he continued to become progressively weaker with decrease in pulmonary functions. On January 18, 1977 he was intubated and a tracheotomy was performed. By January 22 he was breathing comfortably with positive pressure unassisted ventilation. His weakness was generally unchanged at this point.

Case 3. A 17-year-old high school girl (patient of Dr Stanley Boyer) had received no inoculations within the past year. There had been no specific respiratory illness, although she had had some rhinitis during the summer without fever or chills.

About the last week of September she began to have paresthesias of her toes and fingers and some weakness in her lower extremities. It was difficult for her to get around in school and climb stairs. She had some difficulty in gait due to weakness, especially on turns and tandem. There was slight weakness of the facial muscles, definite weakness of sternomastoids, trazepii and neck flexors and of both upper and lower extremities. The weakness was most marked in the lower extremities. There was glove-stocking shading of pinprick sensation at the midcalf and lower forearm level. The deep tendon reflexes were absent. Cerebrospinal fluid was normal with a protein of 38. She improved progressively.

Case 4. A 34-year-old housewife had had no inoculations and no infections. About December 19, 1976 she began to have paresthesias and weakness of the lower extremities which became progressively worse and was most noted on climbing stairs or on arising from a sitting position. The only demonstrable weakness was in the hamstrings and iliopsoas muscles bilaterally, but slightly greater on the right than on the left. Deep tendon reflexes were present. Her spinal fluid on January 5, 1977 showed 11 lymphocytes and a total protein of 28. There was steady improvement by January 10. She was able to climb stairs without difficulty and to climb upon a chair. This was felt to be a partial case of Guillain-Barré with very limited involvement and occurring without a preceding inoculation or infection.

COMMENT

These four cases demonstrate the variations of the syndrome from relatively mild to nearly fatal; from localized involvement (Case 4) to generalized and severe (Cases 1 and 2). Also demonstrated is the variation in the spinal fluid protein.

Two of these cases, 1 and 2, had received the swine flu inoculations, the other two had not.

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Iatrogenic Klebsiella Meningitis Following Closed Needle Biospy of the Lumbar Spine

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Report of a Case and Review of Literature

• A case of Klebsiella meningitis developing six hours after closed needle biopsy of the vertebral disc lesion caused by the same organism is described. The striking temporal relationship and the fact that cerebrospinal fluid was seen to flow out from the biopsy needle during the procedure indicates that the meningitis was a complication of the biopsy; ie, dissemination of existing infection with intrathecal contamination. Awareness of this hazard along with utmost caution during the performance of this procedure may prevent this potentially fatal complication.

HEMATOGENOUS osteomyelitis of the adult has an unexplained predilection for the vertebral column.[1] Vertebral osteomyelitis in adults may follow skin infection, extension from an adjacent infection, urinary tract infections or genitourinary surgical procedure.[2] The association of urinary tract infection with Gram-negative vertebral osteomyelitis has been well documented.[3-5] Closed needle aspiration biopsy of the vertebral spine using the technique of Ottolenghi or the Craig modification is not infrequently used as the diagnostic procedure to establish the bacterial etiology of the lesion more so if this is not forthcoming from blood cultures or the clinical setting. We wish to report a fatal case of Klebsiella meningitis occurring as a complication of vertebral needle biopsy which to our knowledge is the first one documented.

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Case Report

An 83-year-old male was admitted in January 1974 to the Veterans Administration Hospital, Madison, Wisconsin, for an evaluation of gross, painless hematuria. The patient complained also of dribbling and nocturia. His medical history included recurrent episodes of renal stones, urinary tract infections, and the presence of benign prostatic hypertrophy.

His urinalysis showed pyuria and a urine culture was positive for Klebsiella pneumoniae > 500,000 colonies/cu cm. The day after admission he became febrile with shaking chills. Blood cultures taken at that time were also positive for Klebsiella. His hematocrit reading was 41.2% and white blood cell count 12,100/cu mm with 33% bands and 59% segmented neutrophils. Serum creatinine, blood urea nitrogen, electrolytes, alkaline, and acid phosphatase were all normal. Gentamicin 80 mg, intramuscularly. every eight hours was initiated, and continued for seven days. Several blood and urine cultures became negative. The patient was afebrile, his complete blood count returned to normal but he started complaining of persistent low back pain. Lumbosacral spine films showed only degenerative changes. An intravenous pyelogram disclosed nephrolithiasis and a large bladder calculus. The latter was crushed and the pieces removed through a cystoscopic procedure. The patient was discharged taking analgesics for his back pain four weeks after admission.

Three weeks later he was readmitted with increased low back pain. He was afebrile and vital signs were stable. A repeated intravenous pyelogram was unchanged. Lumbosacral spine films and tomograms of L_{3-4} area were obtained and now revealed osteomyelitis. Complete blood count and differential were normal but the erythrocyte sedimentation rate was 50 mm per first hour (Wintrobe). Serum rheumatoid factor was negative, and BIC (C3 complement) was normal. Several blood and urine cultures were negative.

A Craig needle biopsy of the disc space of spinal L_{3-4} area was attempted under fluoroscopic control. During the procedure, the dura mater was torn and clear spinal fluid was noted to flow from the biopsy needle as it was being withdrawn. Six hours after the procedure the patient became confused and febrile. A lumbar puncture was performed and a turbid cerebrospinal fluid (CSF) revealed a white blood cell count of 7,500/cu mm with 98% polymorphonuclear cells, red blood cell count of 3,500/cu mm, glucose of 7 mg/100 ml, protein 824 mg/100 ml. Both the disc space biopsy and the CSF cultures were positive for Klebsiella pneumoniae.

The patient was treated with chloramphenicol 1.5 gm intravenously every six hours, gentamicin 100 mg intravenously every eight hours, and gentamicin 10 mg intrathecally daily for 29 days. A normal CSF flow study and radionuclide myelogram was obtained with intrathecal injection of 1.5 mCi of 99^m Tc in the lumbar region. The minimal inhibitory concentration (MIC) of chloramphenicol against the Klebsiella organism obtained from the CSF culture was 0.75 μg/cu cm and the MIC of gentamicin was 1.56 μg/cu cm. With the antibiotic treatment the CSF cultures became negative but its white blood cell count was 520/cu mm, red blood cell count 1,400/cu mm, glucose 98 mg/100 ml, and protein 344 mg/100 ml.

Despite intensive medical support, he became more confused, developed grand mal seizures, inappropriate antidiuretic hormone (ADH) syndrome, severe metabolic acidosis, and renal failure. Finally, he died 30 days after the needle biopsy. A postmortem examination was not obtained.

Discussion

Although closed needle aspiration had been in use since 1932, it was not until 1948 that Valls and Ottolenghi[6] described safe and accurate techniques for making ap-

proaches at all spinal levels. Since then several series[7-11] have emphasized the benign nature of the procedure with proper technique. Possible complications include rare instances of minor bleeding[7] easily controlled using gelfoam. The possibility of the needle entering the arachnoid space identified by flow or aspiration of cerebrospinal fluid has been mentioned[7,10] and it is suggested that the direction of the needle be changed. Two cases of pneumothoraces and one case of pneumonia with same organism being cultured from the biopsy specimen and the sputum were reported by Gladstein and Grantham.[9] Dissemination of infection in the form of intrathecal contamination with complicating meningitis as it happened in our case has never been reported to our knowledge. Although performed by an orthopedic resident physician under fluoroscopic control, the dura was entered inadvertently and spinal fluid was noted to flow from the needle as it was being withdrawn at the conclusion of the procedure, thus probably disseminating the infection into the intrathecal space. Other possibilities such as the meningitis resulting from bacteremia or simultaneous rupture of subdural abscess during the procedure cannot be ruled out but the chronological sequence of events makes it extremely unlikley.

Iatrogenic meningitis[12] following diagnostic lumbar puncture, spinal anesthesia, and pneumoencephalography have been documented, Pseudomonas aeruginosa being the common etiologic agent in most of these cases. Other Gram-negative organisms like *E coli* and Klebsiella have been incriminated. In this series[12] meningeal signs intervened 12 hours to 10 days following the procedure. Possible sources of bacterial contamination are the anesthetic solution, unsterile instruments and needles. Staphylococcal and pneumococcal meningitis following pneumoencephalography[13] and Candida albicans meningitis[14] following spinal tap have been reported.

Klebsiella meningitis, although relatively uncommon, is associated with an increased mortality especially if associated with bacteremia.[15-17] Therapy of Gram-negative meningitis necessitates systemic chloramphenicol or alternatively systemic with concomitant intrathecal gentamicin[18] and in difficult cases with suspected or proved ventriculitis intraventricular administration of the aminoglycoside like gentamicin.[19]

Staphylococcus aureus is still the most frequent (60% to 85%) cause of adult pyogenic vertebral osteomyelitis, mostly from hematogenous source.[2] Gram-negative vertebral osteomyelitis is most often associated with urinary tract infections, instrumentation or genitourinary surgery.[20] The other emerging problem is the rising incidence of Pseudomonas vertebral osteomyelitis in heroin addicts[21] thought to be related to self innoculation with the organisms by unsterile injection and subsequent hematogenous spread. Pyogenic vertebral osteomyelitis may present as osteomyelitis of the vertebral body or as an infection of the intervertebral disc.[22] Although the two conditions appear to share a common etiology, they differ in their clinical and radiological presentation. Disc infections are not so widely recognized as those arising primarily in the vertebral body. Our patient had the lesion in L_{3-4} disc and most likely it resulted from the Klebsiella bacteremia which in turn most likely originated from the urinary tract.

Most series on closed needle aspiration bone biopsy indicate that in the hands of experienced surgeons, with strict adherence to the technique and careful fluoroscopic monitoring to guide the needle, the risks are minimal and the yield significant. In our case the contamination of the intrathecal space most likely occurred as the needle was being withdrawn after having been embedded in the infected lesion. Awareness of this complication and exercising the utmost caution not only during the insertion but also during the withdrawal with intensive fluoroscopic monitoring will very likely prevent this serious complication.

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Treatment of Acute Pneumonias*

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PNEUMONIAS are an important clinical entity, being the fifth most common cause of death in the United States. At least a partial explanation for this (perhaps) surprising statistic is that many patients with pneumonia are treated less than optimally. This is in large measure due to the fact that it is difficult (and felt to be impossible by some physicians) to establish a specific etiologic diagnosis in most cases. The classical diagnostic tool, the sputum culture, all too often yields either "normal flora" or organisms which though potentially pathogenic, have nothing to do with the etiology of a given case of pneumonia. It is not surprising, therefore, that many physicians have lumped pneumonia into one large vague diagnostic syndrome and have approached its therapy in a largely empiric or "shotgun" manner.

In his approach to specific therapy, the author found it useful to differentiate pneumonias into etiologic categories summarized in Table 1. Even when the causative agent cannot be identified by the usual microbiological methods, recognition of the fact that different types of pneumonias may possess certain distinguishing clinical and epidemiological characteristics may help in the establishment of specific diagnoses.

The syndrome of "primary atypical" pneumonia (PAP) is a disease of young people, and in populations under the age of 30, it may account for as many as 25% of all cases of pneumonia. The disease is clinically mild ("walking pneumonia"), physical findings are few, and lung involvement is interstitial. It should be emphasized, however, that PAPs comprise only about 5% of pneumonias admitted to a typical municipal hospital. It is virtually impossible to distinguish on clinical grounds *Mycoplasma pneumoniae* pneumonia from pneumonias caused by viruses listed in Table 1. This is unfortunate because erythromycin or the tetracyclines have been found effective against *Mycoplasma pneumoniae* but not against viruses. There is a helpful serologic test, viz "cold agglutinins" which are positive in at least 50% of *Mycoplasma pneumoniae* infections. False-positives occur but are relatively rare. "Secondary" viral pneumonias are generally accompanied by typical exanthems and follow rather than precede their development. Influenza pneumonias usually occur during recognized outbreaks of influenza A. They are clinically much more severe than PAPs. In a suspected case of influenza pneumonia the clinician should be watchful for the complication of secondary bacterial superinfection which generally occurs approximately five to seven days after the onset of the viral infection. Superinfections are characterized by exacerbation of respiratory and systemic symptoms and signs and development of purulent character of the sputum.

Table 1—Classification of acute pneumonias

I. NON-BACTERIAL
- A. "PRIMARY ATYPICAL PNEUMONIA"
  1. *Mycoplasma pneumoniae*
  2. Primary viral: adenovirus, respiratory syncytial, parainfluenza, coronavirus
  3. Rickettsial—"Q fever": *Rickettsia burneti*, psittacosis
- B. "SECONDARY" VIRAL
  Varicella, rubeola
- C. INFLUENZAL PNEUMONIA
  1. Primary viral: influenza virus
  2. Bacterial superinfection: pneumococcal, staphylococcal

II. BACTERIAL
- A. GRAM-POSITIVE COCCAL
  1. *Streptococcus pneumoniae* (pneumococcus)
  2. *Straphylococcus aureus*
  3. Streptococcus group A
- B. GRAM-NEGATIVE BACILLARY
  1. Primary invaders
     a. *Klebsiella pneumoniae*
     b. *Hemophilus influenzae*
  2. Secondary invaders
     Pseudomonas, *E coli*, enterobacter, proteus

III. PRIMARY GRAVITATIONAL LUNG ABSCESS
Mixed anaerobes: streptococcus, bacteroides, fusobacterium

IV. PNEUMONIAS IN "COMPROMISED HOST"
Pneumocystis carinii, candida, aspergillus, cytomegalovirus

*Discussion does not include chronic pulmonary infections caused by mycobacteria or deep mycoses.

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Pneumonias due to bacterial causes are more common in middle-aged and older individuals. In the elderly, the alcoholics, the hospitalized patients and even those residing in chronic care facilities, Gram-negative bacillary pneumonias are more common than in the otherwise "normal" subjects residing in the community. This is probably due to the fact that these individuals more frequently carry Gram-negative bacteria in the throat. But how to distinguish on the basis of sputum culture organisms which contaminated the sputum during expectoration from the causative agents of pneumonia? It is particularly in these patient populations that transtracheal aspiration may be exceedingly helpful. Two consecutive sputum cultures with the same Gram-negative bacillus predominating also may provide at least a presumptive etiologic diagnosis.

Careful studies have shown that *Streptococcus pneumoniae* (pnemococcus) is still responsible, however, for at least 80% of bacterial pneumonias in adults. Thus statistically, bacterial pneumonias can be considered pneumococcal until proven otherwise. Because blood cultures are positive in as many as 25% of these patients, they should always be obtained on admission. Staphylococcal pneumonias are more common during epidemics of influenza or in patients with enhanced susceptibility to infections such as the diabetics. Sputa are usually loaded with typical organisms. It has been recently recognized that *Hemophilus influenzae* can be a cause of pneumonia in adults. This is particularly (but not exclusively) true in patients with chronic bronchopulmonary disease. Anaerobic pneumonias may appear in two guises, that of a primary gravitational lung abscess or of a necrotizing pneumonia with empyema. These pneumonias occur when infected oral secretions, particularly in patients with tooth and gum disease, are aspirated and gravitate into the bronchus which was most dependent at the time when the aspiration occurred. Thus, if these infected "bronchial emboli" end up in a more central lobule and establish drainage into the bronchus, a solitary lung abscess (with an air-fluid level) may ensue. Conversely, if a more peripheral location is the site of initial infection, bronchopleural fistula with formation of empyema may be the result. Foul smelling character of the sputum or empyema fluid may be a helpful clue.

In individuals whose mechanisms of resistance are severely suppressed, the so-called pneumonias of the "compromised host" are common. The best (if not the only) way of establishing a diagnosis is by obtaining tissue by either an open lung or transbronchial biopsy. Newer diagnostic tools are being developed

Table 2—Antibiotic therapy of pneumonias

CAUSATIVE AGENT	ANTIBIOTIC REGIMEN: *1st Choice*	ANTIBIOTIC REGIMEN: *Alternate for penicillin allergic*
A. Pneumococcus	Procaine penicillin G, 600,000 units IM q12h, or Aquous (potassium) penicillin G, 200,000 units IV q4h	Erythromycin, 500 mg PO or 250 mg IV q6h; lincomycin, 600 mg IV q8h; cephalothin, 1.0 gm IV q6h (if reaction not anaphylactic)
B. *Staphylococcus aureus*		
Penicillin resistant	Nafcillin, 1.0 gm IV q4h	Cephalothin, 1.0 gm IV q4h; vancomycin, 500 mg IV q6h
Penicillin sensitive	Aq pen G, 2 M units IV q4h	
C. *Klebsiella pneumoniae*	Gentamicin 1.5 mg/kg/-dose q8h (if renal function normal), IV or IM (cephalothin may be added)	Cephalothin, 2 gm IV q4h (only rarely used alone)
D. Other Gram-negative aerobic bacilli	Gentamicin, as for klebsiella. Carbenicillin, 30 gm/day, to be added in pseudomonas infection	Based on susceptibility testing
E. *Hemophilus influenzae*	Ampicillin, 2 gm IV q6h	Chloramphenicol, 0.5 gm IV q6h. Susceptibility testing required as many strains are now resistant to ampicillin
F. *Anaerobes* (gravitational lung abscess)	Aq pen G, 1.0 M units IV q4h; or procaine pen G, 1.2 M units IM q6h	Clindamycin, 600 mg IV q6h
G. *Mycoplasma pneumoniae*	Erythromycin or a tetracycline, 500 mg PO q6h	
H. *Pneumocystis carinii*	Pantemidine, 4 mg/kg/-day IM or co-trimoxazole (exp)	
I. Candida, aspergillus	Amphotericin B, ≈ 2 gm total over 4-6 weeks	
J. Unknown: Not severely ill	As for pneumococcal pneumonia	
Critically ill	Nafcillin, 1 gm q4h IV and gentamicin 5 mgm/-kg/day in 3 divided doses IV	

and will eventually make etiologic diagnoses in pneumonias easier to establish. These include detection of bacterial antibodies and antigens in various body fluids by counterimmunoelectrophoresis and recognition of distinct metabolites resulting from bacterial growth *in vivo* by gas gromatography. Hopefully in the not too distant future some of these procedures will become widely available.

When the specific etiologic diagnosis is established or suspected, the antibiotic choices should be as outlined in Table 2. One point which needs emphasis is that adequate therapy of pneumococcal pneumonia can be accomplished with only moderate amounts of penicillin; *ie,* 1.2 million units per day. This is due to the fact that all the strains of pneumococcus isolated in the United States to date are still sensitive to penicillin. Using larger doses is not only unnecessary, but may actually lead to the development of superinfections. When the etiological diagnosis cannot be established and the patient is not severely ill, the author would treat the patient with penicillin as for pneumococcal pneumonia. If, however, the patient is critically ill, and particularly if he falls into the clinical categories which are more prone to have a staphylococcal or a Gram-negative bacillary pneumonia, he would treat them with nafcillin and gentamicin to provide broad spectrum coverage. Unfortunately, there are still no drugs effective in viral infections and as far as primary viral respiratory infections are concerned, vaccines are only generally available for influenza.

One should also pay attention to such ancillary modes of therapy as oxygen, antitussive agents, analgesics, and diet. Aspirin should be avoided unless the patient is very "toxic" as it may alter the fever curve and mask this very important parameter of therapeutic response. Codeine may be helpful for pain and cough. An additional important approach is that of "bronchial toilet" which is directed towards enhancement of expectoration of bronchial secretions and evacuation of infected alveolar exudates. This may be facilitated by intermittent positive pressure breathing apparatus and postural drainage. Diet during the initial stages of pneumonia should be semi-liquid or soft as it is better tolerated by the patient and provides less of a risk of aspiration.

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PERINATOLOGY

SUPPORTED BY THE WISCONSIN PERINATAL CENTER, SOUTHCENTRAL REGION, MADISON

EDITOR: Luis B Curet, MD, Professor, Department of Gynecology-Obstetrics, University of Wisconsin Center for Health Sciences-Madison General Hospital, Madison, Wisconsin

In the management of high risk pregnancies the perinatologist is frequently faced with the dilemma of a preterm fetus with pulmonary maturity. The decision to deliver or not is frequently clouded with uncertainty because of the absence of data bearing on the problems such babies suffer postnatally.

The following article by Dr Gary Gutcher, a neonatology fellow at the Wisconsin Perinatal Center, Southcentral Region at Madison General Hospital, sheds some light into the problem.

The Preterm Fetus with Mature Lungs

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THOUGH THE lecithin/sphingomyelin ratio (L/S) has provided a powerful predictive tool of fetal lung maturity regarding Respiratory Distress Syndrome (RDS), increasing dialogue between neonatologists and obstetricians in a perinatal approach has suggested the potentially dangerous tendency to equate "mature L/S" with "mature fetus." A retrospective study was undertaken to elucidate the outcome of "immature fetuses" with "mature L/S."

During a six-year period, the Hartford Neonatal Research Labora-

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Table 1—Mortality

A. PERINATAL		
Term:	1—hydrocephaly, craniocentesis	<1%
Preterm:	1—stillborn, GC	3%
	1—hydrocephaly, ? Carr syndrome	
	1—asphyxia, precipitous delivery	
B. NEONATAL		
Term:		0%
Preterm:		2%

Table 2—Morbidity

	Term (%)	*Preterm (%)*
1. Asphyxia	7	19
2. RDS	0	2
3. RDS II/lung water	2	22
4. Apnea and bradycardia	<1	5
5. Pneumothorax, pneumomediastinum, pneumopericardium	<1	1
6. Sepsis, abscess, pneumonia	<1	4
7. Suspect sepsis	<1	15
8. "Feeding problems"	<1	31
9. Metabolic disorders	<1	25
10. Hyperbilirubinemia (not ABO or Rh)	3	30
11. Overall morbidity	18	77

tory performed 386 L/S ratios in which the results indicated fetal lung maturity. Of these, 41 were excluded from review because of inadequate data, 252 delivered at greater than or equal to 37 weeks gestation (term), and 93 delivered at less than 37 weeks gestation (preterm).

The mortality in the "term" and "preterm" groups appear in Table 1. Table 2 tabulates the calculated incidence of morbidity in the two groups and Table 3 cites data relevant to morbidity and medical costs.

Table 3

	Term	*Preterm*
Hospitalization time	4 days	12 days
Laboratory studies per patient	2	15
Number of infants with at least one roentgenogram	9%	39%

It is evident that a "mature L/S" virtually eliminates *mortality* from RDS but does not exclude *morbidity* from RDS, particularly in the preterm infant. The L/S value reflects a major factor in the pathophysiology of RDS but not *all* factors responsible for this complex disease and, like any laboratory determination, can never be totally predictive.

Some of the morbidity associated with the preterm group can be anticipated on the basis of general immaturity ("feeding problems," apnea, bradycardia, and hyperbilirubinemia) and may superficially appear to be minor problems. However, each one often requires therapeutic intervention with new modalities that may have long-term (and as yet, unknown) consequences such as the use of respiratory stimulants and phototherapy. This general immaturity of all organ systems also places the infant at higher risk for life-threatening disease such as sepsis.

The longer hospital stay and increased number of laboratory and roentgenographic studies underscore the notion of prematurity itself as an unnatural state. The physician's heightened sensitivity to symptoms in a preterm infant correctly elicits a more investigative, invasive response which may not always be to the patient's benefit.

In general, despite a "mature L/S," a high incidence of problems must still be anticipated in those infants born prematurely. If one views the anticipated prematurity itself as an unnatural, disease-prone state, then the L/S should be interpreted not as an *indication* for delivery (as in a repeat cesarean section) but only as *permissive* of delivery. It is permissive in its relative accuracy in eliminating the major threat of RDS. It does not eliminate the problems associated with immaturity of other organ systems. Clearly, each pregnancy must be managed as a unique event with maternal-fetal factors for and against early delivery. The L/S is only one factor. ■

ABSTRACT
WISCONSIN AUTHOR

Hereditary Spherocytosis: A Study of Splenectomized Persons

ROBERT F SCHILLING, MD, University of Wisconsin Medical School, Madison, Wis: *Semin Hematol* 13:169-176 (July) 1976

Sixty-one persons splenectomized for hereditary spherocytosis have been studied and compared to 36 nonsplenectomized clinically affected and to 77 nonaffected family members. Serum IgM levels were reduced by 25% and IgD levels were nearly doubled in the splenectomized group. No fatal bacterial infection was identified by history covering a total of 800 postsplenectomy years.

Platelet counts remained elevated for many years after removal of the spleen, as did the number of leukocytes, lymphocytes, and monocytes. Heinz bodies were seen in 3% of red cells after splenectomy. Although within the range of "normal," reticulocyte levels and serum bilirubin levels were statistically higher in the splenectomized group than in the nonaffected persons. Hemoglobin levels were higher in splenectomized affected persons than in matched controls of the same sex and maturity. ■

Cystic Fibrosis in an Infant Presenting with Metabolic Alkalosis

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IN PEDIATRIC PRACTICE, the most common cause of a significant metabolic alkalosis is the loss of hydrochloric acid due to the persistent vomiting in hypertrophic pyloric stenosis.[1] The other relatively common cause of metabolic alkalosis is potassium depletion which may occur during long-term diuretic therapy,[2] or potassium depletion associated with primary or secondary hyperaldosteronism states,[3] and Bartter's syndrome.[4] Uncommonly, metabolic alkalosis results from administration of bicarbonate, lactate or citrate salts.[2] Rarely, cystic fibrosis in infants may present as metabolic alkalosis.[5,6] We recently had an opportunity to study a four-month-old boy with failure to thrive, hypochloremic metabolic alkalosis, high serum aldosterone values, and who was found to have cystic fibrosis.

Case Report

The patient was a boy, born at full term weighing 2.56 kg. His growth and development progressed normally for six weeks. He then became "fussy" on his regular formula feeding, hence his feeding was changed to Neo-Mull-Soy.* At that time his sodium intake was 10 mEq in 24 hours. Although he sweated profusely, no importance was placed, as both parents also perspired heavily. At 12 weeks of age, he developed a "cold" with mild cough and fever of 38 C. He lost all interest in food and despite absence of vomiting or diarrhea, he lost 1.2 kg body weight and weighed 5 kg.

During his hospital stay for diagnostic evaluation of his failure to thrive, his blood showed hypochloremic alkalosis. Etiologically, hypertrophic pyloric stenosis was unlikely due to absence of history of vomiting or abdominal mass on examination and with a normal upper gastrointestinal tract on radiographic examination. Despite fluid management and absence of diarrhea or vomiting, he lost weight and persisted with metabolic alkalosis.

When transferred to Milwaukee Children's Hospital, he was mildly dehydrated and weighed 4.56 kg and his blood pressure was 80 systolic. The rest of the physical examination was unremarkable.

The laboratory studies are summarized in Table 1. Chest x-ray film showed mildly hyperinflated lungs with focal atelectasis on the right lower lobe of the lung. Hypochloremic metabolic alkalosis was confirmed. Random urinalysis at that time showed pH 5.5, specific gravity 1.023 and 2+ protein. His blood urea nitrogen was 21 mg per 100 ml and serum creatinine was 1.0 mg per 100 ml. His liver function studies were normal and serum protein electrophoresis was normal.

A possible diagnosis of Bartter's syndrome was entertained. Analysis of timed urine specimen showed minimal urinary sodium loss and no urinary chloride loss, making the diagnosis of Bartter's syndrome unlikely.

On evaluation of the family history, there were infant deaths due to lung problems on both sides of the parent's family. The history of increased sweating also became important. On three separate occasions, sweat chloride estimated by pilocarpine iontophoresis was 104, 130 and 130 mEq per liter (normal up to 50 mEq/L). Trypsin was present in the stool in normal amounts. A diagnosis of metabolic alkalosis and cystic fibrosis became evident.

The child was given intravenous (IV) replacement of normal saline. After only 12 hours of IV therapy, the child improved enough to take oral feedings. Four days after therapy, electrolytes and acid base balance were normal. Some of the other studies are summarized in Table 1.

At the age of 11 months, the child's weight was normal, but trypsin content of the stool was low. The child was given oral supplement of pancreatic enzymes. His serum electrolytes are normal. He has high values of plasma renin and aldosterone despite extra salt intake (Table 1).

Discussion

In cystic fibrosis, serum sodium and chloride levels may be low either due to acute salt loss in sweat as in "heat casualties,"[7,8] or due to slow progressive salt loss in sweat as during winter months.[9,10] Additionally, poor salt intake as in breast milk feeding[6] may contribute to low serum sodium and chloride values. Like Gottlieb's patients,[5] our patient had normal serum sodium value, low serum potassium and

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Table 1—Laboratory studies

	NORMAL VALUES								
Hospital Day (No.)		1	2	3	5	6	7	8	Age 11
Body Weight (kg)		4.56			4.56	4.74	4.89	4.93	Months
Serum Sodium (mEq/L)	136-143	138	137	138	138	136	136	145	140
Serum Potassium (mEq/L)	3.5-5.5	3.7	2.7	3.2	3.3	2.8	3.8	3.8	4.2
Serum Chloride (mEq/L)	98-108	73	74	75	75	84	89	106	107
Serum Bicarbonate (mEq/L)	18-27				44	35	35	25	21.4
pH	7.35-7.45	7.64		7.60	7.55	7.53	7.53	7.50	7.33
pCO_2 (mmHg)	35-45		47		48				
BUN (mg/100 ml)	5-20				21	26			15
Serum Creatinine (mg/100 ml)	0.5-1.0				1.0	0.8			
Serum Calcium (mg/100 ml)	9-11.5				12.0	10.8	11.9		
Serum Phosphorus (mg/100 ml)	4.7				6.7	5.4	6.9		
Alk. Phosphatase (Bodansky Units)	3-5					7.0			11.1
Hematocrit (vol %)		39			36.2				41
Hemoglobin (Gm/100 ml)		13.4			12.7				13.8
Serum Cortisol (μg/100 ml)	5-20				28.8 (4 pm)				
Serum Aldosterone (ng/100 ml)	2-9				38			110	25.4
Plasma Renin (ng/ml/hr)	0.5-1.6								4.12
Urinary pH		7	5	5	5.5		7.5		7.5
Urinary Specific Gravity		1.020	1.013	1.010	1.023	1.010	1.005		
Urinary Sodium (mg/24 hr)						1.0			24
Urinary Potassium (mg/24 hr)						5.0			69
Urinary Chloride (mg/24 hr)						0			43
Urinary 17 OHCS (mg/24 hr)	0.1-0.5					0.4			
17 KS (mg/24 hr)	0.5					0.5			
Sweat Chloride (mEq/L)	Up to 50				104			130	130

chloride values and metabolic alkalosis. Low serum chloride may be due to loss of chloride in sweat (sweat chlorides above 100 mEq/L). Loss of chloride through kidney (urinary chloride 0) or gastrointestinal tract (absence of diarrhea or vomiting) seem unlikely.

Renal response to the hypochloremic metabolic alkalosis is to regenerate bicarbonate ion by the renal tubular cells. This occurs in two phases. The initial renal response to hypochloremia would be to reabsorb all available urinary chloride ion with sodium ion and excrete bicarbonate ion with sodium or potassium ion.[1] This will cause urine to be alkaline. With continuing loss of potassium and sodium with bicarbonate ion, coupled with inadequate intakes, the body stores of sodium, potassium, and chloride will decrease. This sets up the second phase of the renal response of perpetuating metabolic alkalosis.

Initiation of the second stage needs two separate mechanisms. One, a situation for avid sodium ion reabsorption, and the second of hypochloremia,[1] both due to a low salt intake or an increase salt loss. Both of these mechanisms were possibly operating in our patient. He was taking low sodium intake of 10 mEq per day and, although not specifically measured, he was certainly losing increase sodium as chloride in his sweat.

The kidney in this phase has to choose between conservation of sodium and potassium ions or correction of metabolic alkalosis. The kidney elects to conserve sodium and potassium ions and perpetuate metabolic alkalosis. Sodium reabsorption occurs avidly in exchange for hydrogen and potassium ions which are excreted. This causes "paradoxical aciduria" as was shown in our patient with a urinary pH of 5.5 when the blood pH varied between 7.55 and 7.64 and total CO_2 was 44 mEq per liter. With loss of each hydrogen ion, the kidney generates a new bicarbonate ion. This keeps plasma bicarbonate concentration high and also causes progressive potassium depletion. This then perpetuated the metabolic alkalosis in our patient.

Clinically, this problem can be analyzed by estimating urinary chloride. Absent or very low urinary chloride, with low serum chloride, suggests extra renal causes of chloride ion loss as in persistent vomiting, excessive sweating in cystic fibrosis or gastrointestinal losses,[11] and responds well to replacement of chloride ion as sodium or potassium chloride. The kidney can then retain chloride ion in exchange for bicarbonate ion, which is excreted turning urine pHs alkaline. When our patient improved, urinary pHs were alkaline. Patients with Bartter's syndrome and other aldosterone type metabolic alkalosis will excrete high urinary chloride and may not respond as well to sodium chloride replacement.[11]

The other reason for continuation of the metabolic alkalosis in our patient may be hypokalemia due to secondary hyperaldosteronism.

Children with cystic fibrosis have moderately elevated plasma renin and secondarily elevated serum aldosterone value. This is due to chronic sodium chloride loss through sweat.[12] Our patient had high serum aldosterone values associated with only slightly elevated

serum cortisol value. High serum aldosterone value increased further despite correcting conditions which stimulate aldosterone secretion; *ie,* sodium chloride deficiency and also not giving extra potassium. This suggests that long-standing salt depletion is not the *only* cause for abnormal renin-aldosterone system.[12]

Contraction of intravascular volume following frequent excessive sweat loss of sodium and chloride ions and subsequent adaptive increase in renin and aldosterone also may be contributing.[12]

Seven months later the patient still had above normal plasma renin and serum aldosterone values despite normal electrolytes (Table 1). Similar adaptive increase in renin and aldosterone has been reported in older children and adults with cystic fibrosis.[12]

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Ruptured Popliteal Cysts Mimicking "Thrombophlebitis"

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TENDERNESS, edema, and inflammation of the calf usually suggest acute deep vein thrombophlebitis. Cellulitis, rupture of the plantaris muscle, and rupture of gastrocnemius muscle can simulate these findings, but a careful history and physical examination permit correct diagnosis. The less common entity of ruptured popliteal cyst also can mimic deep vein thrombophlebitis. Incorrect diagnosis of this entity may result in ineffective anticoagulant therapy that can increase morbidity and unnecessarily prolong hospitalization. We have seen six patients who illustrate this diagnostic challenge.

Case Reports

Case 1. A 40-year-old obese male complained of swelling of the left popliteal space for two weeks. Three days prior to admission the popliteal swelling disappeared, but tenderness and swelling of his left calf developed. Physical examination showed a diffusely tender, tense, red calf. We instituted heparin therapy and on the third day continued anticoagulation with coumadin. Despite adequate anticoagulation, the patient's pain and erythema continued. A venogram was performed and was normal. Anticoagulants were discontinued, and an arthrogram demonstrated a ruptured popliteal cyst with extravasation of contrast material into the calf (Figs 1 and 2). Injection of 25 mg of prednisolone into the left knee joint resulted in rapid improvement over the next 48 hours. Ten days later only minimal stiffness remained in the calf.

Case 2. An 86-year-old female was hospitalized for progressive bilateral leg edema. For 20 years she had rheumatoid arthritis, which had been inactive for many months. Physical examination revealed congestive heart failure with edema of both lower extremities. Greater edema, tenderness, and erythema of the right calf suggested thrombophlebitis. Diuretics, elastic stockings, and anticoagulant therapy were initiated. The patient was discharged from the hospital, but right calf tenderness and swelling persisted over the next month despite anticoagulant treatment. On readmission we obtained a normal venogram and anticoagulants were discontinued. An arthrogram disclosed severe osteoarthritis and a large ruptured popliteal cyst extending into the right calf. Forty milligrams (40 mg) of prednisolone injected into the right knee joint resulted in improvement for a month. However, swelling of the right calf recurred over the subsequent six months.

Case 3. A 61-year-old male was admitted because of a two-week history of increasing right calf pain and stiffness of hand joints. He had rheumatoid arthritis, which had been inactive for three years. On examination, the right calf was diffusely tender, warm, and swollen. No evidence of a palpable vein could be found. Despite

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heparin therapy the pain and swelling continued. On the second hospital day we noted an effusion in the right knee and obtained a normal arthrogram. A 30-minute delayed film, however, showed extravasation of contrast material into the right calf. After an intra-articular injection of 40 mg of prednisolone, the patient became asymptomatic in four days. There was no recurrence of right calf tenderness during eight months of observation.

Case 4. A 38-year-old female with rheumatoid arthritis complained for three weeks of progressive left calf pain, swelling, and redness. She was treated with phenylbutazone two weeks previously. Although the redness decreased, the pain and swelling continued. Physical examination revealed no evidence of active arthritis, but the left popliteal and calf area were swollen and tender. There was no erythema or palpable vein. Dissection of a popliteal cyst was considered. An arthrogram of the left knee demonstrated a small popliteal cyst and contrast material extravasating into the posterior calf. The patient declined treatment and was discharged without follow-up.

Case 5. A 61-year-old female developed extreme tenderness in the right knee and a warm, tender, cystic mass in the right suprapatellar area. She also had a palpable mass in the right popliteal fossa and mild edema of the right lower leg. The patient had rheumatoid arthritis resulting in limited extension of the right knee. A diagnosis of active rheumatoid arthritis and suprapatellar dissection of a synovial pouch (the equivalent of a popliteal cyst) were made. An arthrogram was not considered necessary for confirmation of this diagnosis. The right knee and suprapatellar cyst were aspirated and an injection of 40 mg of prednisolone was instilled into the suprapatellar cyst. Complete relief of symptoms was seen in one week. Gold and salicylate therapy was initiated. Although the suprapatellar cyst persists, the patient continues to have relief of symptoms after a year of observation.

Case 6. A 14-year-old male sustained a traumatic football injury to the right knee. A fracture was not seen but three weeks after the injury he noted pain and a "clicking" sensation in the knee. An arthrogram revealed that the menisci were intact. However, the posterior capsule was torn and contrast material extravasated into the soft tissues of the calf. Immediately after the arthrogram, the patient noticed increasing right calf pain and swelling. Three days later a tense, tender, warm right calf without a palpable vein was found. We suspected a tissue reaction to extravasated contrast media. Surgery disclosed a medial meniscus and posterior capsular tear and no evidence of thrombophlebitis. The patient has had no further symptoms.

Discussion

In 1840 Adams[1] first described popliteal cysts. Baker[2] reported eight cases in 1877 and subsequently reported 10 other patients in whom disease in the adjacent knee was present. He first recognized the difficulty in the differential diagnosis between ruptured popliteal cysts and venous thrombosis (in one patient). In 1964 Good[3] reported six cases of ruptured popliteal cysts in patients with rheumatoid arthritis and emphasized their frequent association. Bryan[4] discussed six cases without rheumatoid arthritis and suggested that other forms of arthritis may result in a ruptured popliteal cyst.

Dixin[5] described experiments in which cadaver knees were injected with fluid to the point of rupture and concluded that the suprapatellar pouch and the popliteal area were the two points of synovial weakness. Of the six bursae around the knee, the semimembranous bursa most frequently communicates

Figure 1—Dissection of popliteal cyst. Posteroanterior view.

Figure 2—Dissection of popliteal cyst. Lateral view.

with the joint. Wilson[10] described communications between knee joints and popliteal cysts in 17 of 30 cadaver dissections.

The exact cause of the edema and erythema caused by rupture of a popliteal cyst is not known. Normal synovial fluid dissecting into the leg does not seem to produce symptoms.[5] Associated venous thrombosis has not been found surgically[3] or with venography.[7] Compression of the popliteal vein by a popliteal cyst can contribute to the edema. It seems likely that the inflammatory exudate following rupture of the popliteal cyst dissects within muscle bundles producing edema and redness of the calf.[6]

Ruptured popliteal cysts often are mistaken for acute thrombophlebitis because of their similar clinical presentations of pain, swelling, and redness. Palpable cord-like veins often are found in acute thrombophlebitis but are not felt with ruptured popliteal cysts. Failure to respond to anticoagulant therapy (Case 1) and a palpable cyst in the popliteal fossa with the patient standing also should alert the physician to this diagnosis. The most consistent clues to diagnosis are the history of arthritis of the adjacent knee or the finding of knee fluid (Case 3). Rheumatoid arthritis is commonly the cause of knee effusion, but any knee disease with synovial effusion may lead to a ruptured popliteal cyst. A normal venogram can not confirm the diagnosis of ruptured popliteal cyst; however, it does force the physician to consider a diagnosis other than thrombophlebitis (Cases 1 and 2).

The diagnosis of ruptured popliteal cyst is confirmed by an arthrogram. Fifteen to 20 ml of renografin is injected into the knee joint followed by flexion-extension at the knee before x-ray films are obtained. Hench[7] emphasized the presence of ball-valve connections between the knee and cyst cavity and the need for knee movement to force contrast material into the cyst. We have found that 30-minute delayed x-ray studies may be the only diagnostic films (Case 3). We also have seen symptoms caused by extravasation of contrast material into the calf (Case 6), but this does not seem to be a consistent clinical problem. Schmidt et al[6] have recently suggested joint scanning after intra-articular injection of iodinated I^{131} serum albumin as a benign and effective means of establishing the diagnosis.

Two treatments have been used to relieve the symptoms of ruptured popliteal cysts. Injection of glucocorticoids into the knee joint produces dramatic relief of symptoms.[3,7] Aspiration of the cyst without the subsequent injection of glucocorticoids is ineffective.[8] The recurrence rate after medical treatment is not known, but recurrences can be treated again. Synovectomy also has been used to control symptoms. Kirpila and Ripatte[9] found only minor recurrences in 3 of 17 patients. Bryan[4] feels that early surgical treatment should be done to prevent recurrences in patients with rheumatoid arthritis. It is our opinion that intrasynovial injection of glucocorticoids should be the first line of treatment because of its ease, low morbidity, and usual success; surgery should be reserved for the patients failing to respond or those with frequent recurrences.

Summary

Ruptured popliteal cysts often are mistaken for acute thrombophlebitis because of their similarities of calf swelling, erythema, and pain. A history of knee disease with synovial effusion commonly preceeds the ruptured popliteal cyst and can alert the physician to consider the diagnosis. Diagnosis is confirmed by an exercise arthrogram. Symptoms can be controlled effectively by glucocorticoid injection into the synovial space, but symptoms may recur. Synovectomy also has been used for symptomatic control. We present six cases of ruptured popliteal cysts mimicking thrombophlebitis to illustrate the similarities of presentation, the common history of associated knee disease, and the importance of clinical awareness in order to diagnose and treat the condition effectively.

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ABSTRACT

Wisconsin Neurological Society

Ataxic Guillain-Barre Syndrome, A Pathological Investigation

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Presented at the Spring Meeting of the Wisconsin Neurological Society, May 30-31, 1975, in Oshkosh, Wis

A 62-year-old man presented with ataxia and areflexia. He subsequently developed an acute motor polyneuropathy with multiple cranial nerve involvement. The patient died because of respirator-related complications. Complete pathological examination of the central and peripheral nervous system was performed and the positive findings consisted of marked demyelination of the peripheral nervous system. No spinal cord or cerebellar lesions were detected.

This case supports the hypothesis that the ataxic form of Guillain-Barré syndrome is due to demyelination of the large proprioceptive peripheral nerve fibers, and supports the hypothesis that the Guillain Barré syndrome and the syndrome of ophthalmoplegia, ataxia, and areflexia (Fisher's syndrome) are similar. ■

Kidney Biopsy Correlations of Renal Insufficiency and Hypertension

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• To study the relationship between hypertension and renal disease, the blood pressure and serum creatinine levels were correlated with light microscopy renal biopsy findings in 84 patients who had proteinuria and/or renal insufficiency. Forty-four patients had pretreatment mild to moderate hypertension (BP<170/120 mmHg) and 40 severe hypertension (BP≥170/120 mmHg). Eighty-two percent of patients with mild or moderately elevated blood pressure regardless of serum creatinine had primarily glomerular disease and only 2% had primarily nephrosclerotic changes. However, in patients with severe hypertension and mild to moderate renal insufficiency only 14% had primarily glomerular disease and 54% had primarily nephrosclerosis. Where severe hypertension and marked uremia occurred together, the usual finding (67%) was a combination of glomerular disease and nephrosclerosis. Thus in patients with mild to moderate renal insufficiency the pretreatment blood pressure can help predict whether kidney has primarily glomerular or nephrosclerotic lesion.

HYPERTENSION and renal disease frequently coexist in the same patient. When confronted with a patient who has renal insufficiency, proteinuria, and hypertension, it is necessary to determine whether the patient has primary renal disease resulting in hypertension or the renal damage is secondary to essential hypertension. It is not unusual to find proteinuria of more than 3 gm per day due to hypertensive renal disease.[1] To evaluate the relationship between renal disease and hypertension, a retrospective study correlating blood pressure and serum creatinine levels with renal biopsy findings was conducted.

Materials and Methods

Renal biopsy specimens obtained from 84 patients were examined by light microscopy. The biopsies were done for evaluation of renal insufficiency and/or proteinuria. The specimens were evaluated jointly by a nephrologist and a renal pathologist. The presence of marked intimal hyperplasia, onion scaling or fibrinoid necrosis of the arteroles was regarded as diagnostic of severe nephrosclerosis.[2] The presence of local or diffuse glomerular proliferation, capillary thickening, hyalinization, and focal necrosis was considered indicative of glomerular disease. The pathological diagnosis included nil disease, focal, proliferative and membrano proliferative glomerulonephritis and membranous glomerulopathy. Patients with systemic diseases such as diabetes and amyloidosis were not included in the study. Since we did not have electronmicroscopic and immunofluorescence studies on all our patients, no attempt was made to make specific diagnoses for the purpose of this study. Pretreatment blood pressure and serum creatinine levels were obtained from a review of the patient's medical record.

Results

Patients were assigned to one of two groups according to their blood pressure readings. Forty-four patients comprising Group I had mild to moderately elevated blood pressure (<170/120 mmHg) and 40 patients, Group II, had severe hypertension (BP≥170/120 mmHg) (Table 1). Thirty-six (82%) of the patients in Group I showed one or more features of glomerulopathy with little or no nephrosclerosis, whereas only four (10%) of the patients in Group II manifested glomerulopathy alone ($p<0.05$). Severe nephrosclerosis alone was present in one patient only (2%) in Group I whereas 17 (43%) of the patients in Group II manifested this finding ($p<0.05$).

To study the relationship between the biopsy findings and renal function, Groups I and II were divided into two subgroups on the basis of serum creatinine level (Fig 1). In patients with mild to moderate hypertension the histological findings were essentially the same irrespective of serum creatinine. Among patients with severe hypertension and creatinine levels of 4 mg/100 ml or less, 15 of 28 (54%) manifested severe nephrosclerosis

Table 1 — Renal biopsy findings in all patients

	GROUP I (BP<170/120)	GROUP II (BP≥170/120)
Normal biopsy	2 (4%)	7 (17%)
Glomerulopathy alone	36 (82%)	4 (10%)
Nephrosclerosis alone	1 (2%)	17 (43%)
Glomerular disease and nephrosclerosis	5 (12%)	12 (30%)
TOTAL	44 (100%)	40 (100%)

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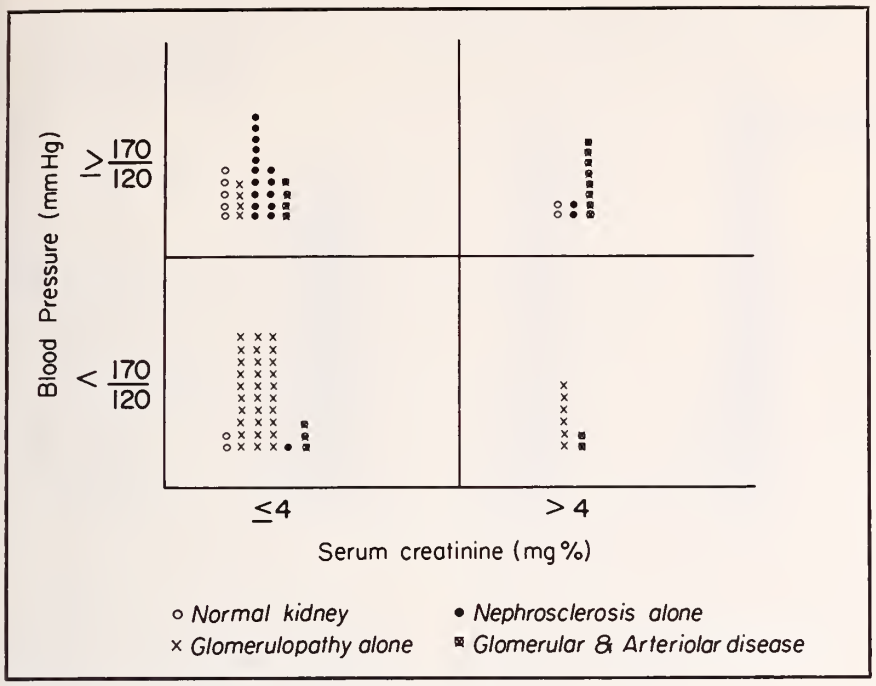

Figure 1 — Correlation of kidney biopsy findings with serum creatinine and blood pressure levels.

primarily. Of those with serum creatinine levels higher than 4 mg/100 ml, 8 of 12 patients (67%) showed a combination of glomerular disease and severe nephrosclerosis and none showed glomerular changes alone (Table 2).

Discussion

Heptinstall[3] has described increasing grades of nephrosclerosis and arteriolar necrosis in renal biopsy tissues with increase in blood pressure levels. Similarly, our data revealed little nephrosclerosis in patients with mild to moderate hypertension but marked nephrosclerosis in patients with severe hypertension. Control of hypertension might, therefore, halt the process of nephrosclerosis and prevent the development of renal damage. Allison et al[4] have demonstrated that renal vascular necrosis in rabbits will resolve by lowering elevated blood pressure with antihypertensive agents.

Our data indicate that patients with glomerulopathy alone seldom manifest severe hypertension. The mechanism resulting in mild to moderate hypertension in patients with glomerulonephritis and mild renal insufficiency is not clear. It cannot be due to increase in renin secretion alone since the plasma renin levels in these patients are normal.[5] It may, however, be due to either an imbalance of renin secretion and extracellular fluid volume or decreased secretion by the kidney of certain naturally occurring antihypertensive substances such as prostaglandins.[6]

Two-thirds of the patients with severe hypertension and severe renal insufficiency showed a combination of extensive glomerular scarring and severe nephrosclerosis on kidney biopsy. None of this group had glomerular changes alone. This group of patients may have developed glomerular renal damage secondary to malignant hypertension. That marked elevation of blood pressure over a prolonged period leads to glomerular damage is best demonstrated in patients with unilateral renal artery stenosis. In such patients the kidney with normal renal artery develops arteriolar and glomerular necroses while the kidney with stenosed artery is protected from the effects of high blood pressure and is usually normal on microscopic examination.[2] Glomerular injury is probably a direct result of intense ischemia as similar changes have been demonstrated in rabbits by embolic obstruction in intrarenal arteries.[7]

Our data thus indicate, in patients with renal insufficiency and hypertension the pretreatment blood pressure can help decide whether the kidney disease is primarily glomerular or nephrosclerotic.

Table 2 — Renal biopsy findings in Group II patients (BP≥170/120)

	Serum Creatinine≤4 mg%	Serum Creatinine>4 mg%
Normal biopsy	5 (18%)	2 (17%)
Glomerulopathy	4 (14%)	0 (0%)
Nephrosclerosis alone	15 (54%)	2 (17%)
Glomerular disease and nephrosclerosis	4 (14%)	8 (67%)
TOTAL	28 (100%)	12 (100%)

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Diuretic-induced Hyperuricemia: A Possible Solution

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• Hyperuricemia on a renal basis is observed frequently in the untreated hypertensive population and becomes much more prevalent after treatment — especially with conventional natriuretic agents. The utilization of new natriuretic antihypertensive agents possessing substantial intrinsic uricosuric activity presents one possible solution to this problem. We are reporting preliminary data on ticrynafen, one such agent.

PERHAPS one-fourth of patients with untreated essential hypertension have serum uric acid values exceeding 7 mg/100 ml.[1-4] In addition, ample evidence documents the observation that the treatment of hypertensives approximately doubles the prevalence of hyperuricemia.[1-6] Although several types of antihypertensive medications tend to increase the serum urate by decreasing the renal uric acid clearance, the natriuretic diuretic agents have been implicated most frequently. At least initially, these agents diminish the renal urate clearance by causing some degree of extracellular fluid volume contraction secondary to diuretic-induced salt and water losses.[7]

What are the dangers of protracted hyperuricemia? Because the limit of monosodium urate solubility in plasma occurs when the urate concentration approaches 7 mg/100 ml, a tendency toward deposition of monosodium urate in articular and other tissues would be an initial concern. However a recently published prospective study of 124 persons, seemingly normal in all respects except for asymptomatic hyperuricemia, failed to demonstrate an increased incidence of gout after more than three years of observation.[8] On the other hand, those individuals *did* demonstrate an enhanced incidence of hypertension and glucose intolerance during the follow-up interval. Other investigations have indicated that persons with advanced chronic renal insufficiency, but without articular gout, can develop intrarenal urate deposits, presumably as a consequence of hyperuricemia.[9-10] Thus, although unproven, it is tempting to speculate that hyperuricemia might result in intrarenal urate deposition and tend to accelerate the development of hypertension and chronic renal insufficiency. Indeed, the well known association of hypertension with renal involvement and gout provides some indirect support for this hypothesis. Also, in a recent series of 101 patients with chronic interstitial nephritis, hyperuricemia was implicated (although unproven) as the only etiologic factor in 11.[11]

Given that patients with essential hypertension and normal renal function are likely to exhibit some degree of hyperuricemia secondary to sluggish renal excretion of urate,[1,2] and that their treatment—especially with diuretics—may exacerbate this hyperuricemic tendency,[1-6] what therapeutic alternatives are available? It has been demonstrated amply that diuretic-induced hyperuricemia may be prevented or controlled either by the blockade of renal tubular urate reabsorption with uricosuric pharmacologic agents or by the inhibition of urate synthesis with allopurinol. On the other hand, the addition of either allopurinol or a uricosuric agent to the therapeutic regimen poses two potential difficulties. First, in patients who already receive a large number of drugs, the addition of another agent for long-term prophylaxis of hyperuricemia might further tax compliance in the patient with an already complicated medical regimen. Second, additional therapeutic agents pose additional toxic hazards. For example, the implications of allopurinol ribonucleotide formation in patients receiving allopurinol over the long term are not presently clear.[12] Thus, utilizing our currently available therapeutic armamentarium, the physician must weigh the disadvantages of prescribing an additional agent against the possible adverse sequelae of long-term hyperuricemia.

Fortunately, an alternate treatment strategy may become available. A number of compounds possessing substantial uricosuric activity, in combination with potent natriuretic and antihypertensive properties, have been developed and tested in several animal species. One of these currently is available for investigational use in the United States. This agent, generically termed ticrynafen (code number,

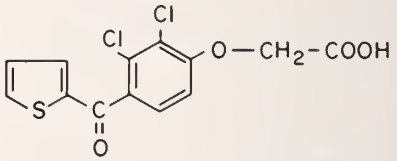

Figure 1 — Structure of ticrynafen. Note that the compound is a phenoxyacetic acid derivative, bearing some similarity to ethacrynic acid (Edecrin®). Ticrynafen is also known as SKF-62698 in the United States, and as tienilic acid (ANP-3624) in Europe.

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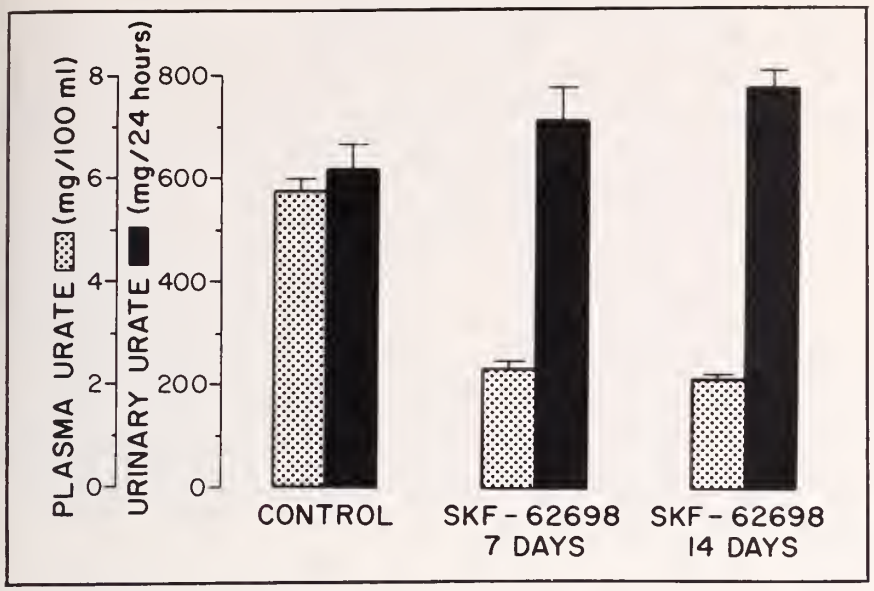

Figure 2 — Reciprocal changes in plasma and urinary urate after 7 and 14 days of ticrynafen (SKF-62698), 250 mg twice daily. Values are means and standard errors in 11 normal persons.

SKF-62698), is a substituted dichlorophenoxyacetic acid derivative (Fig 1). Although it bears some structural similarity to ethacrynic acid (Edecrin®), ticrynafen probably acts at a different nephron site in man. Instead of inhibiting sodium chloride reabsorption in the thick ascending limb of Henle's loop, ticrynafen appears to act within the cortical distal nephron and possibly the proximal nephron.[13]

In seven normal persons, the administration of a single 500 mg dose of ticrynafen resulted in a stepwise increase in sodium excretion to approximately 500 μEq/minute within three hours.[14] Concomitantly, there was an even sharper increase in the urinary uric acid excretion to a plateau greater than 1600 μg/minute—more than triple their control excretion rates. By three hours, the serum urate had decreased by an average of 1 mg/100 ml. During the protracted administration of ticrynafen in 11 normal persons at a dosage of 250 mg twice daily, the serum urate diminished and stabilized at a value of approximately 2 mg per deciliter (Fig 2). Both the serum and urinary uric acid values tended to stabilize after seven days of ticrynafen administration.

Unlike the thiazide diuretics or ethacrynic acid and furosemide, ticrynafen did not acutely increase the excretion of potassium, calcium, or inorganic phosphate. However, during chronic administration, serum potassium fell by 0.5 mEq/liter —probably a consequence of diuretic-induced secondary hyperaldosteronism.[15] The renal clearance and excretion of magnesium tended to be increased following both the acute and chronic administration of ticrynafen.[14,15] In contrast to thiazides, chronic ticrynafen administration in our hands did not elicit a significant decrease in the urinary calcium excretion or clearance.[15]

Preliminary data in the literature,[16] and studies currently in progress at our institution, have indicated that the natriuretic and antihypertensive actions of ticrynafen are similar to those of the thiazide diuretics. Ticrynafen, at a dosage of 250 mg, appears to manifest both natriuretic and antihypertensive activity similar to that of 500 mg of chlorothiazide or 50 mg of hydrochlorothiazide. In addition, the intrinsic uricosuric activity of ticrynafen is far greater than that of any commercially available natriuretic antihypertensive agent. This unique uricosuric property is responsible for the pharmacogenesis of *hypo*uricemia, rather than *hyper*uricemia, during chronic administration.[17]

Natriuretic antihypertensive compounds possessing a high degree of uricosuric activity may provide a means of evaluating the degree of danger (if any) of long-term hyperuricemia in treated hypertensive populations. In addtion, assuming that the avoidance of hyperuricemia is judged beneficial, agents such as ticrynafen could allow the physician treating hypertensive patients to avoid any harmful sequelae of long-term hyperuricemia.

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Diagnosis of Bleeding Meckel's Diverticulum

Theodore Rowan, MD and **John P Hansen, MD**
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APPROXIMATELY 2% of otherwise normal individuals have a Meckel's diverticulum as a remnant of the omphalomesenteric (Vitelline) duct, usually 1 to 2 cm in length and on the antimesenteric side of the intestine. This lies 8 to 10 cm above the ileocecal valve at birth, lengthening to about 1 m in the adult. Rarely it remains attached by a fine cord to the umbilicus and very rarely it is noted at birth to be widely patent and in communication with the exterior of the body. The mucosa may be similar to that of the rest of the ileum or it may contain areas of gastric, duodenal or colonic mucosa, or occasionally have ectopic pancreatic tissue. Approximately one-fifth of these diverticula contain gastric mucosa and the ability of gastric mucosa to selectively take up technetium 99m pertechnetate has been utilized for this and other purposes.

Jewett[1] in 1970 first described visualization of a Meckel's diverticulum in two patients by this technique, and there have been a number of subsequent articles on its usage in the preoperative diagnosis of rectal bleeding secondary to bleeding Meckel's diverticulum.[2-8] Two recent series have added additional information. In one 100 patients with suspected Meckel's diverticulum were reviewed, 33 patients underwent surgery. Of these eight had negative scans, and one of these was a false negative, there being a Meckel's diverticulum which contained little gastric mucosa. The remaining 25 positive scans showed one false positive and one equivocal scintigram. (One of these had ectopic gastric mucosa).[7] In the other series results were collected from several centers, and the results of 114 surgically proven Meckel's diverticula evaluated. There were 43 true positive and 46 true negative scans with 11 false positive and 14 false negative. This gives a specificity of 79%, sensitivity of 75%, and accuracy of 78%.[8] It also has been reported of use in diagnosing other ectopic foci of gastric mucosa, intrathoracic gastrogenic cysts,[9] Barrett's esophagus[10] (a case of which we found when scanning for a Meckel's diverticulum), and in gastric malignancy.[11]

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Report of a Case

This 4-year-old boy was brought to his family physician in April 1976. The parents gave a history of the child having had dark red stools over one to two weeks. These occurred about once per day and were not associated with any pain, fever, or other abdominal symptom. He was becoming weak and seemed to be excessively sleepy.

On examination the pulse was 100 and his temperature was 99.2 F (37.3 C). The abdomen was nontender and normal bowel sounds were present. Rectal exam revealed currant jelly colored stool which was positive for occult blood.

The patient was admitted to the hospital with a hemoglobin level of 6.0 gm/100 ml and hematocrit value of 20%. During the evening of admission, he passed more bloody stools and he became restless and lethargic. His pulse rate increased to 140. Repeat hemoglobin and hematocrit were 5.2 gm/100 ml and 14.5% respectively. The patient received 2 units of packed cells over an eight-hour period and the next morning the hemoglobin was 13.7 gm/100 ml and hematocrit 39.5%.

Proctosigmoidoscopy and barium enema were normal the morning after admission and technetium 99m scan of the abdomen performed revealed an abnormal focus of activity in the mid-abdomen which was consistent with and suggestive of a Meckel's diverticulum.

The following day the patient was taken to the operating room. Laparotomy revealed a 1 x 4 cm Meckel's diverticulum. This was inflamed and edematous by gross inspection. A Meckel's diverticulectomy and appendectomy were performed.

The pathologist reported a diverticulum measuring 2.9 cm by 1 cm. An area of gastric mucosa showing an acute and subacute inflammatory exudate was noted within it. The appendix vermiformis was normal.

Following the surgery the patient had no additional rectal bleeding and was discharged on the third postoperative day with a homoglobin of 13.7 gm/100 ml and hematocrit of 38%. Follow-up two months later revealed no further problems, with stools negative for occult blood and a hemoglobin of 13.3 gm/100 ml and hematocrit of 38%.

Scanning Technique

One and two tenths (1.2) mCi of sodium pertechnetate technetium 99m were injected into an antecubital vein, with no prior preparation of the patient. The bladder was previously emptied. (Potassium perchlorate, which has been recommended in the past, is not used as it may block mucosal uptake.) Multiple views in the supine position were taken approximately 30 minutes after injection. It is currently recommended that one minute anterior images be taken starting three minutes after injection, with right lateral and posterior views taken at 15 minutes, as the maximal uptake is often noted then. This can be repeated at 30 minutes if necessary.

The abnormal focus of activity was noted initially superimposed on the bladder and resembled a bladder diverticulum (Fig 1). By tilting the head down and with minimal abdominal palpation, it was possible to move this focus of activity superiorly and to the right (Fig 2). A lateral view indicated its anterior abdominal location (Fig 3).

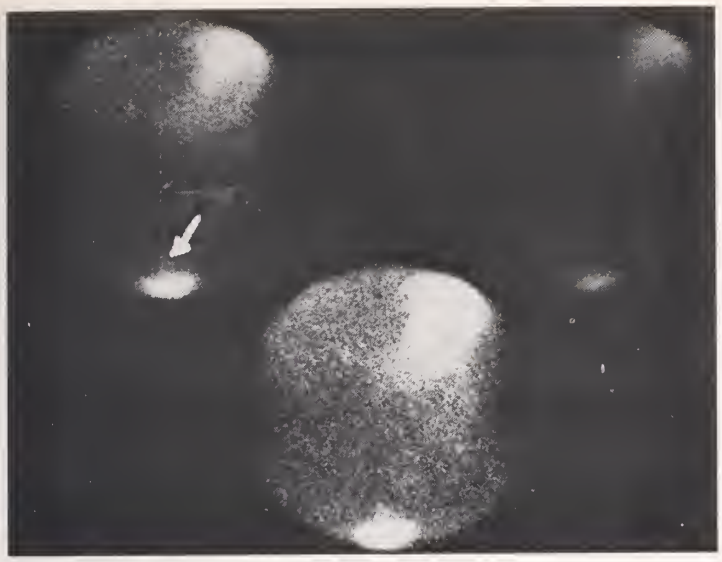

Figure 1—Anterior view showing stomach and faintly discerned focus (arrow) partly superimposed on bladder.

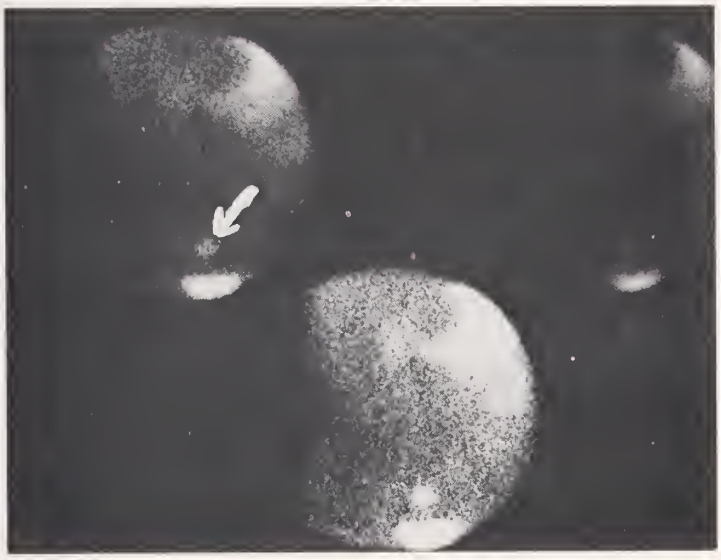

Figure 2—Abnormal focus now clearly delineated.

Figure 3—Lateral view showing anterior location in abdomen.

Comment

Although false negative and false positive examinations occur occasionally, careful technique will demonstrate a Meckel's diverticulum when there is gastric mucosa within, and rectal bleeding is the most common symptom in those patients with ectopic gastric mucosa (approximating 95%). X-ray examinations are almost always negative. Therefore, if a patient has rectal bleeding which is due to a bleeding Meckel's diverticulum, there is approximately a 90% chance of being able to demonstrate this preoperatively with a Tc99m scan. In addition, other abnormal foci of activity (gastric type mucosa) may occasionally be demonstated. Although more common in children, this also may occur in adults.

This is a noninvasive technique, relatively easy to perform, and can be completed in less than half an hour. It should be considered in the examination of patients with rectal bleeding who have a negative proctosigmoidoscopy and barium enema.

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Peutz-Jeghers Syndrome

Cynthia A Therriault and John E McKenna, MD, Antigo, Wisconsin

In Peutz-Jeghers syndrome, the presence of an autosomal dominant gene causes both gastrointestinal polyposis and an abnormal skin and mucosal membrane pigmentation. The polyposis usually involves the jejunum and/or ileum and less frequently the rectum, colon, stomach, and duodenum.[1] About 50% of the cases do involve the large bowel, but it is the small intestinal polyps, which are generally hamartomas, that produce the symptoms of intestinal obstruction and/or bleeding.[2] It is these hamartomas that cause the severe recurrent abdominal pain and anemia. Hematemesis also can be associated with adenomatous polyps of the stomach and/or duodenum.[1]

The abnormal pigmentation, found in 80% of the cases, usually appears in early childhood and consists of melanotic macules that are blue-gray or brown in color, somewhat freckle-like in appearance, located on the lips, buccal mucosa, digits, and rarely on the intestinal mucosa, often fading with age.[3]

Case Report

A 12-year-old girl, youngest of three children, was seen in June 1976 with a three-day history of weakness, vomiting, and loose stools. Upon examination the child was pale and weak with a rapid pulse and lowered blood pressure. She exhibited a hemic grade IV/VI systolic mitral murmur and a black tarry stool. In addition, she was pubertal, having had several menstrual periods.

Significant laboratory findings upon admission were a hemoglobin level of 5.8 mg/100 ml, a hematocrit reading of 17%, a serum iron value of 15 μg/100 ml (normal 65-175) and a 4+ occult blood on a stool specimen.

The clinical impression was acute gastrointestinal (GI) bleeding with near vascular collapse and impending shock. During her hospitalization the patient was given three units of blood and was discharged on the tenth day.

Her history includes the following hospitalizations: In 1966 for an acute viral infection with gastritis and dehydration, later the same month for bronchopneumonia; in 1968 for a T&A, and in January 1975 for acute anemia. During the January 1975 admission, she had a normal upper GI series, small bowel series, barium enema and chest x-ray, but there was some spasticity of the GI bulb, although there was no ulcer. Records state that these tests were performed in order "to rule out familial polyposis." During this same admission "pigmentation on the buccal mucosa" was observed.

During the June 1976 admission, a macular cutaneous pigmentation was noted about the lips and the buccal mucosa, characteristic of Peutz-Jeghers syndrome.

Proctosigmoidoscopy and colonoscopy were done and three adenomatous rectal polyps were removed. Also, multiple small 1-2 mm polyps were noted at about 18-20 cm in the colon. An upper GI series appeared normal except for several small radiolucent shadows seen in the small bowel, which were suggestive of intraluminal jejunal polyps. In addition, a large polypoid mass was seen at the ileocecal valve that the radiologist felt could be an intussusception. Subsequent colonoscopy revealed one adenomatous polyp 2 mm in diameter with no significant findings at the ileocecal valve.

The family tree was obtained; it demonstrated the variable expressivity of the syndrome (Fig 1). As can be seen, one sister of the proband exhibits only the pigmentation characteristic. At this time no further testing has been done to determine whether either of the sisters has evidence of polyps. A most interesting finding was that the mother of the three girls died at age 29 from a primary adenocarcinoma of the fallopian tube; she also had a small mucosal polyp of the cecum. It is also interesting to note that the maternal grandfather of the proband died of cancer of the bowel and was known to have multiple polyps. In addition, his identical twin brother died of cancer nine months later, although it could not be determined through interviews with the family whether he also had gastrointestinal polyps.

Discussion

In distinguishing between other gastrointestinal polyposes, the pigmentation characteristic of Peutz-Jeghers is the key. In the case of

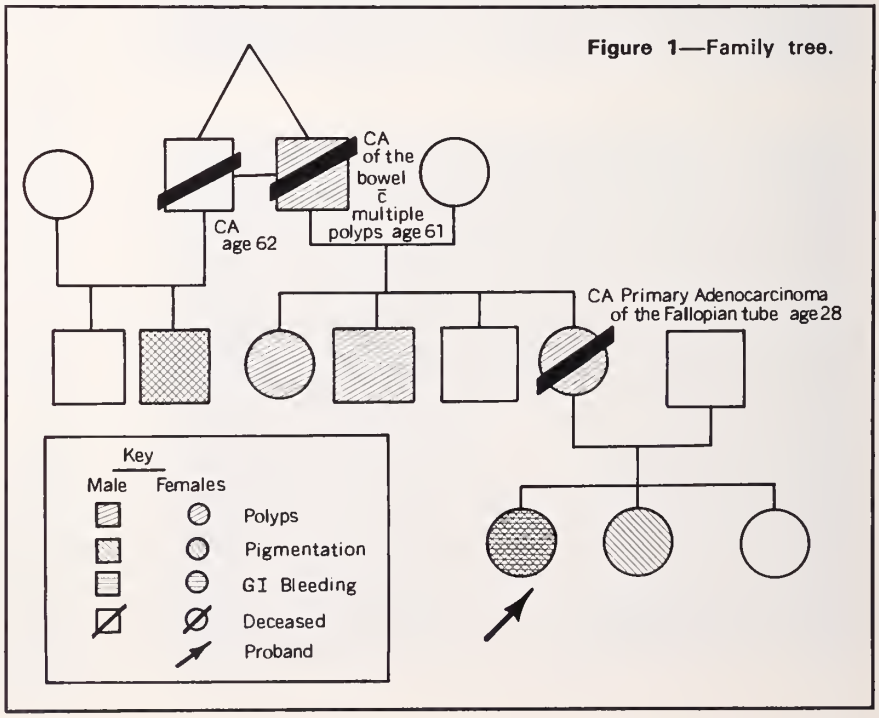

Figure 1—Family tree.

At the time of this study Miss Therriault was a freshman medical student participating in the summer externship program of the Wisconsin Academy of Family Physicians, working with Doctor McKenna.

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familial polyposis and generalized juvenile polyposis, there are no extraintestinal lesions; whereas, Gardner's syndrome exhibits osseous and soft tissue tumors and Turcot's syndrome is associated with tumors of the brain.[1] There also is a greater frequency of symptomatic polyps in the small bowel in Peutz-Jeghers as contrasted with the above-mentioned polyposes, where the major involvement is in the large bowel.[1]

The patient in this study had adenomatous polyps of the colon and the rectum, and also radiologic indications of jejunal polyps. Along with the family history, this points to one of the inherited gastrointestinal polyposes; although the usual, yet characteristic pigmentation exhibited by the proband and her sister points directly to Peutz-Jeghers syndrome.

With Peutz-Jeghers syndrome there is a risk of 2 to 3 percent of developing gastrointestinal cancer, very often in the duodenal region.[1] Also, there has been an increased incidence of ovarian tumors of the thecal cell type found in 5 percent of the females with the syndrome.[4] (It is noteworthy to recall here that the proband's mother died of a primary adenocarcinoma of the left fallopian tube.)

Treatment for Peutz-Jeghers syndrome should be conservative. Symptomatic polyps should be removed by local resection. In addition, any polyps larger than 2 cm in diameter and all gastric and duodenal polyps also should be removed.[1] Development of additional polyps is very likely, so as much gastrointestinal tissue should be left intact as possible.[1]

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ABSTRACT WISCONSIN AUTHORS

Significance of Persisting Serologic Abnormalities in SLE

Robert W Lightfoot Jr, MD and Graham R V Hughes, MD, Wood VA Hospital, Wood, Wis: *Arthritis Rheum* 19:837-843 (Sept-Oct) 1976

The relationship of persistently elevated anti-DNA levels and persistently depressed hemolytic complement levels in 17 patients with SLE (systemic lupus erythematosus) undergoing therapy have been assessed retrospectively. The study attempted to define the significance of persisting serological abnormalities in asymptomatic patients on therapy.

Those patients who had persisting abnormalities of anti-DNA, complement, or both were statistically significantly more likely to have shorter clinical remissions which subsequently terminated more often in major flares (cerebral vasculitis, thrombocytopenia, nephritis. and the like) than patients whose serological tests returned to normal during therapy. Patients not being treated for flares were occasionally observed to have abnormalities of anti-DNA or complement.

Sporadically observed hypocomplementemia most often disappeared without clinical exacerbation. Sporadically observed elevations of anti-DNA usually persisted until a clinical exacerbation ensued. However, the duration of persisting anti-DNA abnormalities was often several years before clinical exacerbation was noticed. There was a direct and significant correlation of steroid dosage used in the first 60 days of treatment to the duration of the ensuing remission.

Patients with persisting laboratory abnormalities in SLE are statistically more likely to flare early and to have major organ involvement when they flare. However, the overlap between groups is such that basing therapy on lab tests alone is not felt to be warranted at present. ■

Report Reye's Syndrome Cases

The Wisconsin Division of Health is asking physicians to report cases of Reye's syndrome to a public health nurse, health department, or the Section of Communicable Diseases, PO Box 309, Madison, Wis 53701.

Because of recent influenza B activity in many parts of the United States, the Communicable Disease Center in Atlanta conducted a telephone survey of 30 state health departments to determine the occurrence of Reye's syndrome. Among 20 states reporting influenza B, 9 states reported 20 cases of suspect Reye's syndrome in the first six weeks of 1977; there were no reported cases in the 10 states not reporting influenza B. Although detailed information concerning most of these 20 cases has not yet been received by the Division of Health, 5 of the 8 children whose outcomes are known died.

Influenza B and myositis: The Pennsylvania State Health Dept has reported 7 cases of myositis following influenza-like illness in children. The cases have occurred primarily in kindergarten and elementary school children. In one family both parents and one child had myositis. The cases have typically presented with severe leg pain, objective muscle tenderness, but no neurological findings several days following onset of an influenza-like illness that occurred in an epidemic setting. The cases have been reported over a four-week period beginning January 18. Each of the patients had been associated with an outbreak of clinical influenza in schools marked by absenteeism of 30% or more and confirmed by serological studies as influenza B. While myalgia is a common symptom of influenza illness, myositis is less common. It has been most frequently reported following influenza B infection in children. Source: National Influenza Immunization Program, Weekly Surveillance Report, Feb 23, 1977, CDC, Atlanta, Ga. ■

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Present and Potential Therapies for Reflux Esophagitis

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GENERALLY, a specific treatment for a disease evolves when the underlying pathophysiology is eventually understood. In the case of reflux esophagitis, no single mechanism seems entirely responsible; multiple factors may contribute to cause this entity. The extent and severity of esophagitis probably depends upon one or more of the following:

1. "Incompetence" of the anti-reflux mechanism.
2. Potency/volume of refluxed material.
3. Duration of esophageal contact with noxious material.
4. Resistance of esophageal tissue to injury.

Therefore, a specific, routinely effective treatment for reflux esophagitis is not available. However, because they influence one or more of the causative factors, several conventional, new and prospective therapies have proved or may prove effective in the treatment of reflux esophagitis.

An anti-reflux mechanism in the human appears necessary to prevent reflux of gastric contents into the esophagus since intraabdominal pressure is higher than intraesophageal pressure. This mechanism is best explained by two basic considerations:

1. *Closure strength* or tone of the *intrinsic lower esophageal sphincter* (LES), and
2. *Mechanical factors* primarily *extrinsic* to the LES.

Medical and operative treatments of reflux esophagitis currently seem divided along lines which encompass one or the other of these explanations for an anti-reflux mechanism.

I. Medical Therapy for Reflux Esophagitis

Most patients with symptomatic reflux esophagitis can be treated by conservative medical management. Treatments are directed toward one of the following areas:

A. Symptom Relief

Antacids relieve heartburn by rapidly buffering the acid reflux within the esophagus.

B. Esophageal "Emptying Time"

Improvement of esophageal emptying time obviously decreases the contact time between the esophageal mucosa and the refluxed noxious material. Parenteral bethanechol and metoclopramide (see below) have demonstrated this capability. Oral metoclopramide does not decrease esophageal emptying time while bethanechol does.

C. Gastroesophageal Reflux

1. Mechanical Factors

(a) *Intraabdominal pressure*—avoid increasing intraabdominal pressure by bending over, wearing constricting garments or gaining weight. Obviously, pregnancy will increase intraabdominal pressure and predisposes to gastroesophageal reflux.

(b) *Posture*—avoid gravity bias; *ie,* prone position during sleep or following meals. Elevation of the head of the bed on six to eight-inch high wooden blocks, is often an effective measure to prevent gastroesophageal reflux which is particularly likely to occur during recumbency and sleep.

2. Habit Factors

(a) *Diet*—avoid fatty foods and individual food "intolerances," which cause reflux; *eg,* tomatoes, citrus fruits, onions, and chocolate.

(b) *Beverages*—ethanol in generous quantity has been shown to decrease resting LES pressure. In particular, types of red wines cause heartburn in reflux-prone individuals.

(c) *Tobacco* — cigarette smoking may be associated with reflux symptoms and has been shown to cause rapid, transient decreases in LES pressure.

3. Pharmacologic Agents

(a) *Antacids*—these agents also appear capable of elevating the

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lower esophageal sphincter pressure by a non-gastrin mediated mechanism.

(b) *Alginate-antacid*—this relatively new agent (Gaviscon®) may decrease the frequency of gastroesophageal reflux episodes. Alginate, a viscus foamy material, allegedly "floats on the surface" of intragastric contents, acting as a physical barrier and retarding reflux.

(c) *Bethanechol* — (Urecholine®) is a cholinergic agent. It has been prescribed in oral dosages ranging from 10 to 25 mg four times daily for patients with reflux esophagitis.

Bethanechol increases basal (resting) LES pressure. To date, the most complete physiologic and therapeutic studies have been done with this drug. It has no pharmacologic influence on serum gastrin levels. Bethanechol has been shown to affect esophageal peristalsis, producing a stronger more sustained contraction wave. Improvement in the clearing of acid (emptying-time) from the distal esophagus has been demonstrated in patients with reflux esophagitis. In addition, bethanechol decreases or abolishes the frequency of gastroesophageal reflux episodes in patients with reflux esophagitis as measured by an intraesophageal pH electrode. Side effects of this drug are usually relatively mild; *ie,* abdominal discomfort, salivation, and flushing. Comparatively large doses may result in effects of parasympathetic stimulation; *ie,* headache, colicky pain, diarrhea, abdominal cramps, asthmatic attacks, and fall in blood pressure. Bethanechol also stimulates gastric acid secretion. Long-term treatment of patients with this medication, however, has thus far demonstrated no increased incidence of peptic ulcer disease or symptomatology.

(d) *Metoclopramide*—(investigational)

In studies to date, metoclopramide has been administered to patients as a single 15 or 20 mg oral dose. (This drug stimulates smooth muscle contraction possibly by facilitating the action of acetylcholine.) Its potential therapeutic use is still under investigation, although the drug has been in clinical use in Europe for almost a decade.

Metoclopramide produces significant increases in LES pressure when given either subcutaneously or orally. In one comparative trial, metoclopramide, 20 mg orally produced a greater sustained increase in LES pressure than bethanechol, 25 mg orally. In another study, oral metoclopramide (15 mg) compared to the antacid, AlMgOH, was more effective in reducing the cumulative duration of gastroesophageal reflux. In the same study, metoclopramide prevented reflux after intragastric acid loading in 8 of 10 patients with proven reflux esophagitis. The acid clearing function and amplitude of esophageal contractions were not affected by the oral preparation of metoclopramide, however.

One other attribute of metoclopramide is its ability to markedly increase gastric emptying. Conceivably this factor could have some therapeutic benefit to patients with gastroesophageal reflux. Side effects with metoclopramide are drowsiness, restlessness, sleepiness, fatigue, agitation, muscle twitching, and abdominal cramping. On rare occasions, extrapyramidal tract disturbances have been reported. In general, the drug is well tolerated by most patients.

(e) *Prostaglandins* (investigational)

Type $F_2\alpha$ prostaglandin has been shown to increase resting LES pressure. Its effectiveness in the treatment of gastroesophageal reflux in the human has not as yet been reported, but therapeutic trials are underway.

(f) *"Biofeedback" Control Mechanisms*

A newly proposed method involving biofeedback control of LES pressure may be of benefit to some patients with reflux esophagitis. This method relies on operant conditioning during esophageal manometric study. Unfortunately, the studies to date show the LES pressure increases in reflux patients amounted to only several millimeters of mercury which was still below the range of normal LES pressure. This mechanism for "training" an autonomic motor function is intriguing, but its clinical usefulness has yet to be established.

4. Decrease Gastric Acid

(a) *Antacids*—Not only do antacids neutralize but also in one recent study they reduced the cumulative duration of GE reflux in a postcibal state (two-hour periods) by buffering acid contents.

(b) *Radiation Therapy*—Gastric irradiation, temporarily and sometimes profoundly, decreases gastric acid secretion. While this modality is infrequently used, in some special circumstances (aged or severely ill patients) it has been found to be effective as a short-term therapy.

(c) *Histamine 2, Receptor Antagonist* (investigational)

H2 Blocker drugs are potent inhibitors of basal and stimulated gastric acid secretion. They do not affect smooth muscle contraction. Cimetidine, the latest H2 Blocker derivative, is currently being evaluated as a treatment for reflux esophagitis by decreasing acid production. Cimetidine does not affect resting LES tone in normal subjects.

II. Operative Therapy for Reflux Esophagitis

Operative management should be considered in patients with severe reflux symptoms, gross esophagitis, and sphincter incompetence who are refractory to medical therapy. An operation should be seriously considered before the esophagus becomes irreversibly damaged by fibrosis and stricture formation.

Other major indications for operative management may be: esophageal stricture formation; esophageal bleeding and pulmonary complications secondary to reflux aspiration.

Current operative treatment for reflux esophagitis is effective in most patients! Modern surgical antireflux procedures such as the Nissen, Hill, and Belsey Mark IV procedures have been directed toward prevention of gastroesophageal reflux rather than the repair of the hiatus hernia per se. The essential elements of these operative repairs are: (1) displacement below the diaphragm of a segment of distal esophagus which allows maximal influence of abdominal pressure on the lower esophageal sphincter, and (2) the wrapping of this segment with a cuff of stomach—the fundoplication. As these operations have now evolved, fundoplication has subsequently been recognized as a "valve building" operation.

These new operative procedures result in dramatic symptomatic improvement in the reflux patients and also significant increases in LES pressure above preoperative values. This increase in LES pressure does not appear to be related to the positioning of the sphincter below the diaphragm; it appears to represent improvement in muscle contractility, as evidenced by the greater response to pharmacologic agents following fundoplication procedure. The current hypothesis explaining the success of the fundoplication is that the procedure changes the length-tension characteristics of the circular muscle of the distal esophagus by stretching its fibers around a mucosal plug of uniform thickness.

Many reports now have verified the efficacy of surgery in alleviating gastroesophageal reflux. Esophagitis generally heals following surgery. These favorable results have been objectively confirmed by followup esophageal pH monitoring and endoscopy. Longer followup periods, however, are needed before we can predict whether the patient who has undergone operative repair for gastroesophageal reflux remains trouble-free.

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ABSTRACT WISCONSIN AUTHORS

Carcinoma of the Cervix in Oral Contraceptive Steroid and IUD Users and Nonusers

HERBERT F SANDMIRE, MD; STEPHEN D AUSTIN, MD; and RICHARD C BECHTEL, MD, Green Bay, Wis:

Am J Obstet Gynecol 125:339-345 (June 1) 1976

Considerable interest has arisen concerning the possible carcinogenic properties of oral contraceptive steroids. In particular the effect of these compounds on the uterine cervix and breasts has been widely speculated. Melamed and associates observed a small but statistically significant increase in carcinoma of the cervix among both pill choosers and pill users when compared to diaphragm choosers and users. He indicated that his results "can be attributed either to a decreased prevalence rate for women using a diaphragm or to an increased rate for women using oral steroids."

Our previous analysis of 15,000 consecutive Pap smears failed to demonstrate an increased risk of carcinoma of the cervix in pill users compared to nonusers. Melamed and Flehinger, in a more recent article, did not reveal any increase in incidence of carcinoma *in situ* and other precancerous cervical lesions in pill users compared to diaphragm and intrauterine device (IUD) users.

In 1960 a cytology registry was organized by two of the three present authors in their practice in Green Bay, Wisconsin. Our present analysis includes the first 40,211 consecutive (1960-1975) Pap smears registered and 780 randomly selected control patients.

Twenty (26.3%) of the 76 carcinoma subjects were currently using oral contraceptive steroids at the time of discovery of their lesions. Two of these patients had invasive lesions and the remaining 18 carcinoma *in situ*. Of 780 control patients, 196 (25.1%) were using oral contraceptives. There were five (9.8%) patients with carcinoma who were not currently using the birth control pill but had used it in the past. Of the control patients 22.8% had used the pill previously. By combining current and previous pill users we have 36.1% of the carcinoma patients with a positive pill history whereas 47.9% of control patients had either current or previous use of the pill. The study also relates duration of use of oral contraceptive steroids to the risk of carcinoma and demonstrates no higher risk in long-term users when compared to long-term control users. It can be seen from these findings that there was no increase in the risk of carcinoma of the cervix when comparing pill users to nonusers.

In conclusion we did not detect any variation in use of oral contraceptive steroids or intrauterine devices in our 76 carcinoma patients when compared to 780 randomly selected control patients. This confirms our previous experience and remains at variance with an earlier report by Melamed, who reported an increase in carcinoma of the cervix among pill users when compared to diaphragm users. This difference could be explained by some protective effect of the diaphragm against the development of cervical carcinoma. A more recent report by Melamed and Flehinger did not reveal any increase in incidence of carcinoma *in situ* and other precancerous cervical lesions in pill users compared to diaphragm and IUD users. ■

LESTER PAUL LECTURE/ by **Per Amundsen, MD**, Oslo, Norway

Myelography and Radiculography—Development of New Contrast Media

THE LESTER PAUL Lecture is an annual presentation which was organized by the residents of the Department of Radiology, Center for Health Sciences, University of Wisconsin-Madison, at the time of Doctor Paul's retirement. In 1976 the Department of Radiology was honored to have Dr Per Amundsen give this presentation. A pioneer in Neuroradiology, Doctor Amundsen's main contributions have been with catheter cerebral angiography and most recently water soluble myelography. Doctor Amundsen always has encouraged exchange between his Department and American universities. This exchange has fostered a close relationship and profitable sharing of ideas between American and Norwegian neuroradiologists. The 1976 Lester Paul Memorial Lecture discusses the recent research activities in Doctor Amundsen's Department involving a new water soluble myelographic contrast agent.—JOSEPH F SACKETT, MD, Department of Radiology, Center for Health Sciences, University of Wisconsin-Madison

DR LESTER W PAUL, Professor of Radiology, in whose honor this lecture is presented, was the second Chairman of the Department of Radiology, University of Wisconsin Medical Center, Madison. It was said of him: "As a physician, teacher, radiologist, and a man, he made major contributions to medical education at the University of Wisconsin." May this lecture be my humble contribution to the celebration of his memory.

The topic chosen for this lecture is based upon a research project in which the Neuroradiological Department, Ulleval Hospital, and three other centers have been investigating for several years. It consists of the clinical trial of a new contrast medium for the subarachnoid space.

The diagnostic possibilities this medium offers will influence the handling of such common diseases as intervertebral disc lesions and surgical nerve root compression. Therefore, even those of us who will not come in contact with it as radiologists may need it as patients.

In England, a neurosurgeon told me that the best way to cure physicians with backache was to tell them that it is necessary to do myelography with iophendylate (Pantopaque®). Our experience indicates that this sort of management may no longer be necessary.

In addition to presenting briefly the new contrast medium, I will discuss the ethical problem of introducing a new substance to be used in humans. The pharmacology and physiology of intrathecal administration of drugs also will be explored.

As a medical student, I detested all those professors who always started with a thorough history of the theme to be taught. I thought they wasted time and in fact many of them did! Growing older, one realizes that knowledge about the road that has led to our present state of development is very important indeed; particularly in order not to repeat the errors and stupidities of the past. This is my excuse for giving a short review of the development of the radiological study of the spinal canal and its contents. The history of myelography is a relatively short one.

First, I would like to draw your attention to what I said a short

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Reprint requests to: Joseph F Sackett, MD, Department of Radiology, University of Wisconsin-Madison, Center for Health Sciences, 1300 University Ave, Madison, Wis 53706.

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minute ago, instead of myelography: the radiological study of the spinal canal and its content. The medulla spinalis, of course, is only one of the structures we want to identify. It does not even exist within the subarachnoid space below the first lumbar vertebra. Therefore, the designation of myelography for this region is fundamentally meaningless. This is why the term "radiculography" has been introduced for the examination of the region below the conus medullaris. Below the conus, the nerve roots, radicles, represent the structures within the subarachnoid space.

The first diagnostic myelography was probably performed by Jacobeaus in 1919. Gas was used as contrast material, and it proved very hard to obtain adequate radiological demonstration of the gas. In 1921 Widero, a Norwegian surgeon, reported on the same technique in 11 cases, injecting gas into the spinal canal. However, he only used the radiating pain as an indicator of the level of the lesion because he was not able to demonstrate it radiologically.

The fact that these trials were done at a very early stage of radiology indicates that there is a need for demonstrating intraspinal pathology. Gas is difficult material to work with as a contrast agent. Iodinated poppy seed oil (lipiodol) was introduced by Siccard and Forestier in 1922. It rapidly became popular. Pantopaque®, introduced at Strong Memorial Hospital, University of Rochester, in 1940 and 1941 had advantages over lipiodol. Pantopaque® also has disadvantages: too high contrast, not mixing with cerebrospinal fluid, and not being resorbed. In 1931 the Swedish investigators Arnell and Lidstrom demonstrated that Abrodil®, which is an iodinated water soluble contrast medium used for urography, could be injected into the subarachnoid space. This contrast material was highly irritating; and if it was allowed to flow above the conus region, serious complications occurred. Even below the conus region, spinal anesthesia was necessary.

From this point onward, the population of radiologists was sharply divided according to the material to be used for the intraspinal subarachnoid space. The borderline of this division ran through Norway. East of us we had Sweden with its big authorities in neuroradiology who said "no Pantopaque®." To our west were the English-speaking colleagues from England who said "no spinal anesthesia," "no water soluble contrast," "Pantopaque® (or as it is called in England, Myodil®) is a wonderful material." In Norway we try to make friends with both sides, so we said we will use both contrast media and take the advantages each one offers.

For the distal subarachnoid space, the radiculographies, we use water soluble contrast medium while for the cervical region we use Pantopaque® when there is a question of a nerve root lesion. We add gas myelography for the remainder of the spinal subarachnoid space. In those days it was great fun to assist in meetings and conferences when East and West discussed these contrast media. There were strong feelings and sharp tongues on both sides. You would surely feel that "East is east and West is west and never the twain shall meet;" however, now we may hope that those famous words of Rudyard Kipling shall no longer be valid in neuroradiology and that these quarrels will soon be only of historical interest.

" . . . nil nocere should apply strictly in groups of patients with basically benign disease."

Abrodil®, methiodal sodium, which was one very early contrast medium designed for urography, held its position as the least irritating of water soluble contrast media for more than 30 years. In spite of the fact that many new water soluble contrast media were developed for intravascular use, Abrodil® remained the least irritating for radiculography. It was not until iothalamate or Conray® was tried for radiculography that progress seemed to move again. From 1968 reports on Conray® used for the lumbar subarachnoid space appeared in the literature. A few years later reports of complications of Conray® radiculography then appeared. The Conray® molecule was modified and the result, iocarmate or Dimer-X®, was developed. Iocarmate also showed side effects and complications indicating that there was still need for improvement. None of these contrast media could be used above the region of the conus medullaris.

What I think we should learn from this history is this: Each new water soluble contrast medium has caused complications—I would rather say accidents. These consisted of lesions of the spinal cord, arachnoiditis, and for the Conray®-Dimer-X® group, seizures with fractures of the spine and hip. Some accidents resulted in death. The majority of these complications should never have occurred since practically all of them were due to faulty technique. These contrast media were used before all details concerning their potential danger had been established. There is another point which is important in this history: All the water soluble contrast media tried, except one, had been originally designed for intravascular use. The history also shows evidence that the evaluation of intravascular toxicity is completely different from intrathecal toxicity. There are conditions, like osmolality, which are more important in the subarachnoid space than in the bloodstream. The new contrast media were tried clinically without much background research in this respect. There is one exception, a compound SH6176, which was designed for subarachnoid use but was

not a true water soluble contrast. The basic research was not adequate before it was supplied clinically, and it was withdrawn from use.

I will now turn to the story of the development of a new contrast medium specifically designed for the subarachnoid space. It has been a long and arduous way to go. The experience gained along the way seems to me to be sufficiently important that it deserves to be reported outside the inner circle of research.

In 1966 Hugo Holtermann, Doctor of Chemistry, Director of Research, Department of the Norwegian pharmaceutical firm Nyegaard and Company, undertook the development of a contrast medium for the subarachnoid space. During 1966 and 1967 a number of compounds were synthesized and screened by simple intracerebral toxicity tests in mice. In 1968 Torsten Almén suggested that non-ionic agents without any salt-forming radicles would give lower osmolality than salt-forming media with the same iodine concentration. Therefore, it would probably give less reaction when injected into the subarachnoid space.

On the basis of this idea, another series of compounds was tried. After elimination by screening tests and selection by more extensive biological tests, one was chosen for further study. The name mertrizamide was given to this compound by the World Health Organization. Metrizamide is compared to Conray® meglumine which is meglumine iothalamate and Dimer-X® which is meglumine iocarmate (Fig 1). One very important point is that this compound does not dissociate and each particle will be a molecule containing three iodine atoms. Conray® dissociates and the particles are ions. Each pair of particles contains three ion atoms which means two times as many particles for the same iodine concentration. Dimer-X® is a polymer but still dissociates. There are six iodine atoms for three particles; that is, 1.5 times as many particles as in metrizamide

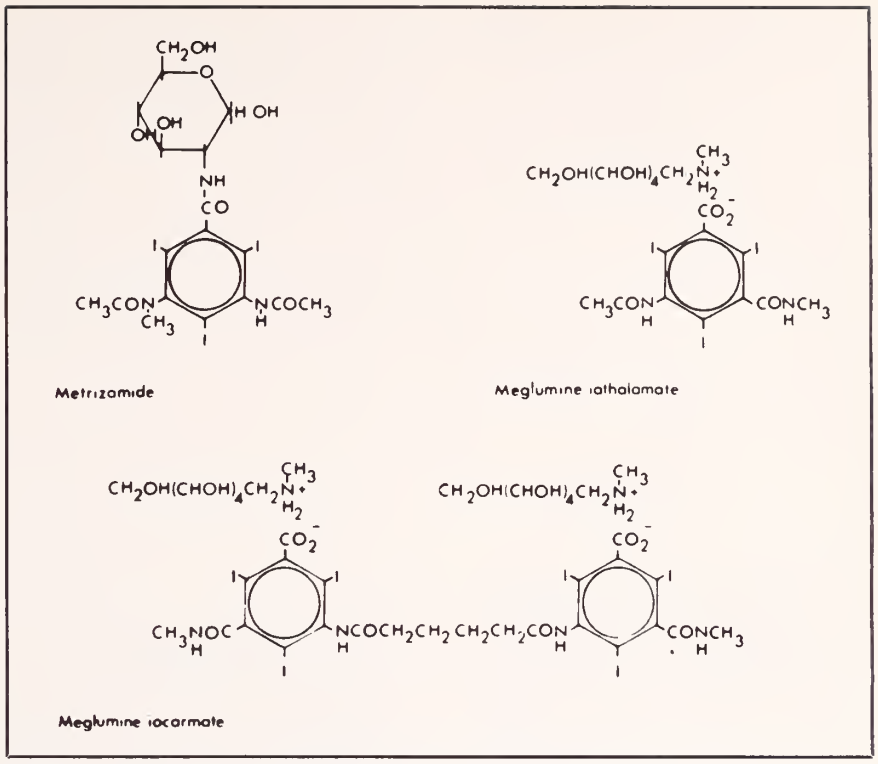


Figure 1—Comparison of metrizamide to meglumine iothalamate and meglumine iocarmate.

for the same iodine concentration. Toxicity also depends upon the anion as well as cation. Anion radicles with very low toxcity have been developed, and most of the adverse effects may be due to the cations, usually sodium or meglumine. The cation toxicity problem has been eliminated by the use of non-ionic compounds.

Extensive biological research was then performed in laboratories of the pharmaceutical firm as well as several hospital research centers in Norway, Sweden, and Belgium. This research continued for four years and showed the metrizamide to have a low toxicity and remarkably low irritating effect on the central nervous system. These research studies were concerned with introduction of metrizamide into the subarachnoid space of experimental animals.

After three years it was decided that it would be safe to test the medium intravenously in humans. This was performed on volunteers, and the results showed that the medium was without side effects when given this way. Another year of further study of subarachnoid application continued; however, before in May 1972, the first clinical testing was allowed. Four medical centers were selected for the pilot clinical study in humans; two in Oslo, one in Stockholm, and one in Belgium. A very close contact was established between these centers so that any reaction occurring in one center would immediately be reported to the others. Because of this close contact, it was discovered that one of the first batches of contrast media caused a high white cell reaction in the cerebrospinal fluid. Immediate investigations into this emphasized again the fact that a medium used in the subarachnoid space needs more strict purification processing for pyrogenic substances than is routine for media intended for intravenous use. It seems to me that this taught us a lesson which should be emphasized these days when so many substances—diagnostic as well as therapeutic—are applied to the subarachnoid space.

Reports on the basic experimental work and on the pilot studies appeared in Supplementum 335 to

Table 1—Animal research—water soluble contrast media

Acute Toxicity	*Intravenous LD_{50}—Mice*
Diatrizoate, Metrizoate, Iothalamate	— 9 - 10g I/kg
Metrizamide	— 17.5 - 18.5g I/kg

Table 2—Metrizamide—clinical pilot study

	Number	*Lumbar*	*Thoracic*	*Cervical*	*Ventriculography*
Gonsette (Belgium)	61	28	18	8	5
Hindmarsh (Sweden)	20	20	—	—	—
Svare, *et al* (Norway)	15	15	—	—	—
Skalpe, *et al* (Norway)	100	100	(50)	—	—
TOTAL	196	163	18 (68)	8	5

Acta Radiologica, 1973. In many of the experiments, metrizamide has been compared to well known contrast media. Diatrizoate is the basic radicle for Urografin® or Renografin®, metrizoate is Isopaque®, iothalamate is Conray®, and iocarmate is Dimer-X®. The acute toxicity is only about half of that of diatrizoate, metrizoate, and iothalamate (Table 1). Liver and kidney toxicity is very low. This also is the case for other contrast media.

The toxicity to the central nervous system is remarkably low; this is an essential point. The capillary toxicity expressed as the blood-brain-barrier test is very low for the known contrast media. It is even less for metrizamide.

The cellular toxicity and epileptogenic effects were found to be much less than the best of the previously-known contrast media. This is the reaction to contrast media directly in contact with brain tissue. Gonsette predicted from this that it would be possible to inject 5 to 10 ml of metrizamide into the spinal canal without causing any irritative effect in the central nervous system.

Meningeal reactions to the subarachnoid, usually suboccipital injection, has been thoroughly tested from both the point of view of change in vital signs as well as histological change. It is questionable whether there are reactions due to the contrast medium itself.

The excretion of the medium is mainly by the kidneys and more than 90% appears in the urine after 48 hours. The pattern is very much like other contrast agents. The absorption from the cerebrospinal fluid in animals is rapid. After three hours practically all the injected contrast medium has been removed to the blood. This is one point where animal experiments and clinical experiments differ. In humans, it has been shown that the contrast travels with the cerebrospinal fluid toward the convexity of the hemispheres and is resorbed much in the same way as has been shown for isotope material.

Table 3—Adverse reactions in 100 examinations (lumbar and lumbo-thoracic region)

Headache	37
Nausea, vomiting	6
Dizziness	13
Accentuated Pain	27

The clinical pilot study was performed by Gonsette in Belgium, Hindmarsh and Greitz in Stockholm, Svare and Talle in Rikshospital in Oslo, and our own group in the Ulleval Hospital, Oslo (Table 2). During this period the examinations were in the lumbar region. Only Gonsette used the medium for a few thoracic and cervical studies and a few ventriculographies. Our group allowed the medium to ascend to the middle thoracic region in the last 50 patients of this series. The concentration of iodine varied from 104 to 300 mg per ml, and the volume usually in the range of 10 to 15 ml.

In this pilot study a long series of parameters were checked in every patient in all the centers. This included very thorough examination of blood and urine, a complete neurological evaluation before and after the examination, and in a number of patients electroencephalography (EEG) was performed before and after myelography. Repeat lumbar puncture was performed for examination of the CSF. Blood and urine as well as general physical examination such as blood pressure, temperature, and the like, did not show any significant change. After the purification of the contrast medium had been perfected, the increase in cell count in the cerebrospinal fluid was found to be very slight with maximum around 24 hours after the injection of the contrast medium. This is in the same range or slightly lower than is the case for pneumoencephalography. The change in protein is very slight, and usually there is no change. The EEG recording showed that a certain number of patients had transient slow-wave activity and epileptiform discharges were never found in this series. The adverse reactions observed in the pilot study were as follows (Table 3): Headache reported in roughly one third of the patients, nausea and vomiting in about 10%, and dizziness a little more frequently. The accentuated pain refers to an increase in the pain with which the patient presented. In most cases this could be explained by the positioning of the patient during and after the procedure. We must emphasize that in this pilot study, no sedative or pain medication was given. The other adverse reactions must be classified as minor. Reports from other centers are in agreement with ours except that Gonsette reported a higher incidence of headache. In none of the centers were any signs reported which could be reported as spinal

cord irritation such as muscle cramps or convulsions. This was even true in Gonsette's series where contrast had obviously been injected into the intracranial cisterns. After this pilot study had been thoroughly discussed by the four centers, together with the research department of the pharmaceutical firm, the clinical trial was continued. At that stage the contrast medium was taken into a higher level in the spinal canal as well as into the intracranial spaces. Still, close contact was kept with the research laboratory as headquarters in order that possible side effects could be made known to all the centers.

The clinical trial has clearly shown that the contrast medium is not completely inert. If brought into the subarachnoid spaces over the cortex in sufficiently high concentrations and amounts, it will cause reaction. This reaction consists of EEG changes, headache and vomiting, and in severe cases, seizures. It has been possible to treat these seizures effectively with diazepam, and no late sequellae have been reported. It seems possible to prevent the more serious reactions, the seizures, by proper technique whereby the contrast medium is not allowed to reach the hemispheres until sufficiently diluted.

After more than two years of clinical trial, our group thought it would be safe to release the contrast medium for general use in the lumbar and low thoracic regions. Clinical trial for the higher level continued and only quite recently has the group decided that we know enough about the medium to advise its use for the rest of the subarachnoid spaces. We think we know how to use it safely.

I believe that we have learned something from our work with this new contrast medium. When a clinical trial is restricted to a small number of highly specialized centers, it can be performed without risk of disasters and is thus ethically defensible. The basic principles for ethics in medicine: *nil nocere* should be applied strictly in groups of patients with basically benign disease. We have learned that even this contrast medium has difficulties and dangers built in it and that it is necessary to now how to use it. We believe we have learned a great deal about what the ideal contrast medium for the subarachnoid space should be. We can see our destiny and feel like the boy in the fairy tale who set out to find his destiny which he called the Soria Moria Castle, the gold castle in the sky, illustrated by the famous Norwegian painter, Kittelsen (Fig 2). Far away behind an unknown, foggy-covered wilderness is the brilliant Soria Moria Castle. The equipment he has to reach there are the traveling provisions his parents have put in his ruck sack, the stick in his hand, and whatever might be underneath his cap. Through many difficulties, this little hero reached his Soria Moria. May we, by the help of what history has given us in our sack, the tools at our hands, and some intelligent brains, be able to safely reach our destiny. ■

Figure 2—Illustration by the famous Norwegian painter, Kittelsen, depiciting a fairy tale hero who sets out to find his destiny which he called the Soria Moria Castle, the gold castle in the sky.

ABSTRACT Wisconsin Authors

Experience with 40,000 Papanicolaou Smears

Herbert F Sandmire, MD; Stephen D Austin, MD; and Richard C Bechtel, MD, Green Bay, Wis:

Obstet & Gynecol 48:56-60 (July) 1976

In 1960 a cytology registry was organized by the authors in their practice. During the ensuing 15 years, 40,000 consecutive cytologic smears and subsequent diagnostic procedures resulted in the diagnosis of 41 carcinomas *in situ*, 35 microinvasive and invasive caricnomas, and 24 severe dysplasias for a yield of significant neoplasia of one lesion per 400 Papanicolaou smears. Twenty-five of the carcinomas *in situ* and microinvasive and invasive carcinomas were diagnosed in patients with atypical smears indicating that all patients with persistent atypical smears require evaluation by tissue examination. Seventy-eight percent of the 119 patients subjected to conization either had carcinoma *in situ*, microinvasive and invasive carcinoma, or significant cervical dysplasia. Postoperative complications following conization were negligible. In addition there were no postconization deleterious effects on three concurrent and nine subsequent pregnancies. Recently available colposcopy can reduce the number of conizations required to evaluate abnormal smears. A history of gonorrhea places a patient at a higher risk of developing cervical carinoma. Annual performance of cytologic smear evaluation is indicated in all sexually active women and in all virginal women over 20 years of age. ■

Etiology and Evaluation of Recurrent Hematuria in Children

Nina Vicente, MD
A Vishnu Moorthy, MD
Russell W Chesney, MD
Madison, Wisconsin

HEMATURIA, gross or microscopic, is an occasional problem confronting physicians caring for children. Although a list of causes is long, trauma and acute urinary tract infection are commonly responsible. Concern over establishing a diagnosis in children with recurrent gross hematuria often leads to the use of invasive urologic procedures such as cystoscopy or retrograde pyelography. The majority of cases are likely to be due to renal parenchymal disease and will not be accurately diagnosed by such techniques.[1] The following six case summaries of children referred with recurrent hematuria to the Pediatric Renal Clinic of the University of Wisconsin Children's Hospital have been selected as illustrative of the predominance of renal causes for such a finding.

Case Reports

Acute Glomerulonephritis

A 9-year-old male developed hematuria accompanied by severe right upper quadrant pain in December 1975. Urinalysis showed microhematuria and 2+ proteinuria. Other studies were: normal erythrocyte sedimentation rate (ESR) (10 mm), antihyaluronidase (64) and ASO titer (125 Todd units), and a normal throat culture. Serum creatinine (cr) was 0.7 per 100 ml and blood urea nitrogen (BUN) 16 mg per 100 ml. Abdominal and chest x-ray film, intravenous pyelogram (IVP), and voiding cystourethrogram (VCUG) were normal. In April 1976 gross hematuria recurred concomitant with an ear infection. He was admitted for a renal biopsy. Studies included hemoglobin 10.2 gm per 100 ml, platelet count 333,000 per cu mm, and ESR 61 mm. His urinalysis had hematuria without proteinuria, white blood cells (WBC) greater than 50 per high-power field (hpf), red blood cells (RBC) greater than 200 per high-power field (hpf). A urine culture was negative. His serum level of the third component of complement (C_3) was decreased at 31 mg per 100 ml (normal 80-160 mg/100 ml). Acute poststreptococcal glomerulonephritis was substantiated by the kidney biopsy findings. His recovery was uneventful.

IgA Nephropathy

A 12-year-old white male had six bouts of gross hematuria in three and a half years occurring with an upper respiratory infection. Group A beta hemolytic streptococci were found on throat culture on three occasions. Previous evaluations including ESR, serum complement, urine culture, IVP, VCUG, and cystoscopy were normal. Renal function tests were normal except for a transient impairment of renal function during his third episode of hematuria, BUN was 42, creatinine 2.9 mg per 100 ml and creatinine clearance was 24 ml per min. These returned to normal in two weeks. His laboratory data included: IgG of 1360 and IgA of 305. Antinuclear antibodies + LE cells were not present. A kidney biopsy was compatible with Berger's IgA nephropathy. He continues to have hematuria with viral infections.

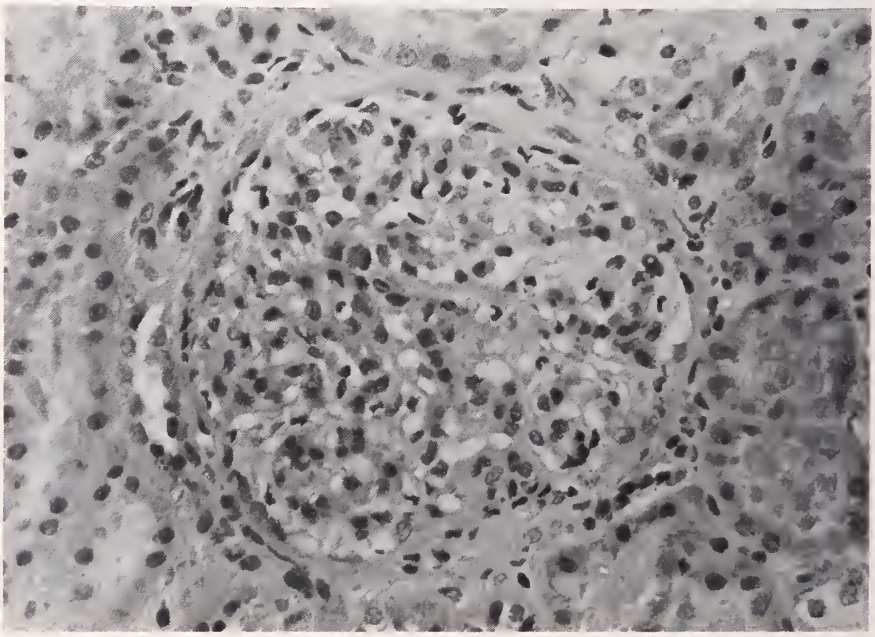
Henoch-Schoenlein Purpura

A 9-year-old boy developed raised purpuric lesions of his buttocks and lower legs while hospitalized for trauma. Within four days joint swelling, arthralgias, and abdominal colic were noted. Microscopic hematuria and proteinuria were found two weeks later. Four weeks later, urinalysis revealed 40-50 RBC per hpf, red cell casts, and 340 mg protein per 24 hours. Abdominal pain and hematuria recurred with upper respiratory infections for a period of nine months, but proteinuria was negligible.

Membranoproliferative Glomerulonephritis

An 11-year-old white girl developed edema, ascites, and hypertension two weeks after an episode of pharyngitis.

Figure 1—Focal areas of increased cellularity and mesangial matrix in a boy with recurrent hematuria (Case 2). PAS Stain × 250.



From the Pediatric Renal Disease Clinic, University of Wisconsin-Madison Center for Health Sciences, Madison.
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Reprint requests to: Russell W Chesney, MD, Dept of Pediatrics, UW-Madison Center for Health Sciences, 1300 University Ave, Madison, Wis 53706.
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Her urinalysis revealed greater than 25 WBC and RBC per hpf and occasional red cell casts. Her urinary protein was 8.2 gm per 24 hours. The serum albumin was 2.2 gm per 100 ml and serum cholesterol 416 mg per 100 ml. Other laboratory studies included: ASO, streptozyme and throat culture normal; ANA negative, C_3 6.8 mg per 100 ml (normal 80-160); hematocrit 38%; BUN 30 and serum creatinine 1 mg per 100 ml. Her nephrotic syndrome was unresponsive to therapy with 80 mg prednisone daily. A renal biopsy was consistent with membranoproliferative glomerulonephritis.

Spontaneous remission of the nephrotic syndrome occurred in 1973; however, active urine sediment and decreased C_3 persisted. In 1976 she complained of easy fatigability, malaise, and gross hematuria. Recurrence of mild hypertension and significant proteinuria were found. The serum creatinine remained at 0.9 mg per 100 ml.

Figure 2—Globular mesangial deposition of immunoglobulin A in the same patient. Mag: × 220.

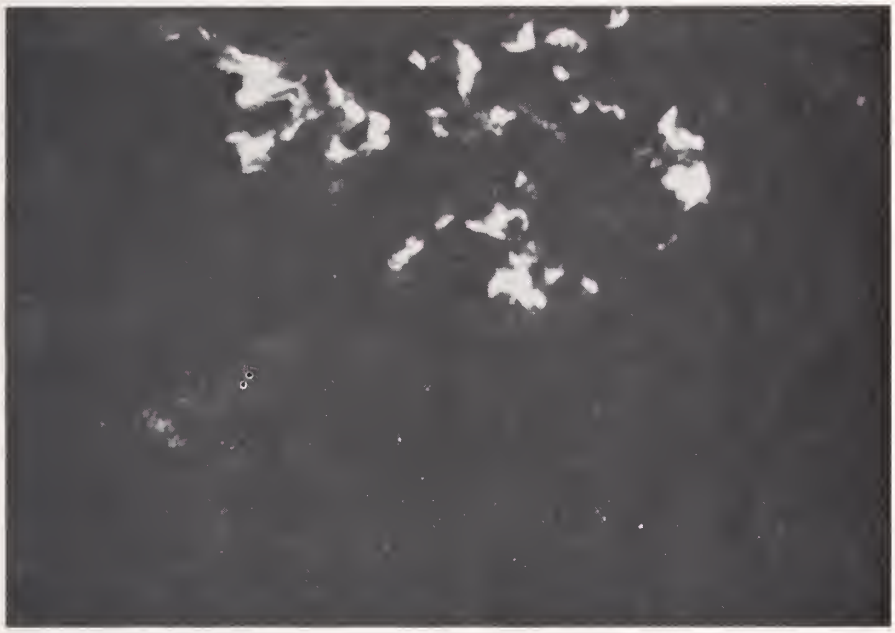
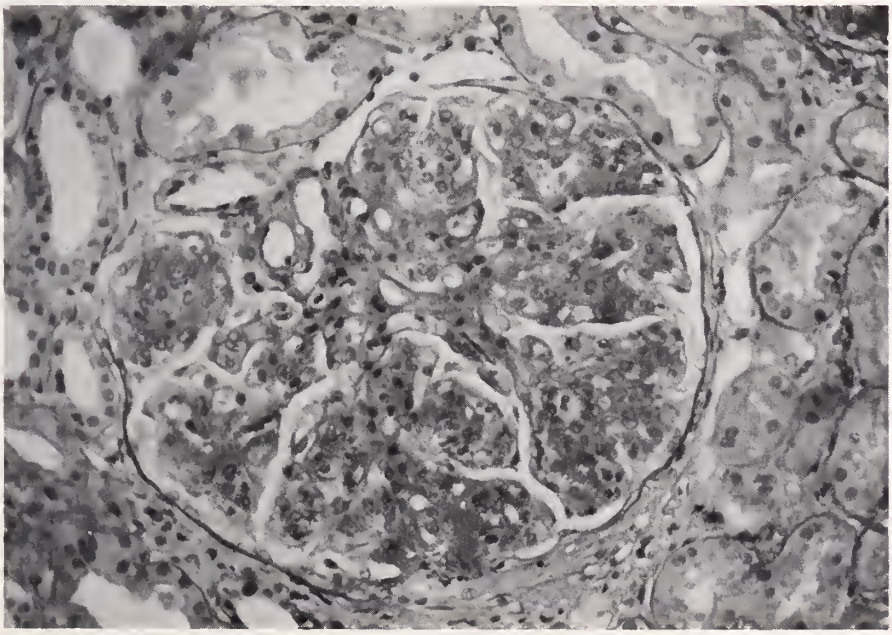


Figure 3—Lobular appearance of glomeruli in an 11-year-old girl with membranoproliferative glomerulonephritis (Case 3). PAS Stain × 250.



Hemolytic-Uremic Syndrome

A 2-year-old girl presented in June 1975, with a week's history of abdominal pain, bloody watery stools, otitis media, fever, and irritability. Gross hematuria was noted three days prior to admission. On admission she was mildly lethargic and had generalized edema present. Her blood pressure was 145/94 mm Hg.

Laboratory investigation included: hemoglobin: 3.9 gm per 100 ml, platelet count 24,000 per cu mm; peripheral blood smear with many fragmented red blood cells and helmet cells suggestive of intravascular hemolysis; serum creatinine 4.8 and BUN 104 per 100 ml, and serum potassium 5.3 mEq per liter.

She was treated with fluid restriction, sodium polystyrene sulfonate (Kayexalate®) and parenteral hydralazine therapy. She became anuric with a serum creatinine rising to 12.6 mg per 100 ml. Peritoneal dialysis was performed for a 48-hour period. Three days after dialysis, she had a diuresis with concomitant improvement in anemia and thrombocytopenia. The hematuria cleared and serum creatinine fell to 2.2 mg per 100 ml. Her blood pressure was 140/100 mm Hg and she required oral hydralazine 40 mg daily for control. When seen ten months later, the patient was doing well. Her serum creatinine was 0.7 mg per 100 ml and she continues to be on a small dose of hydralazine for adequate control of blood pressure.

Systemic Lupus Erythematosis

A 15-year-old white girl was admitted to the hospital in February 1975 for evaluation of an erythematous pruritic rash in the butterfly area of the face and swelling and stiffness of wrists and finger joints present for six weeks. Her family history disclosed many family members having polyarthritis, a cousin with systemic lupus erythematosis and an elder sister with a similar facial rash, but with no arthritis. Urinalysis on admission revealed more than 50 red blood cell casts per high-power field. Urinary protein excretion was 4.9 gm per 24 hours. Her serum creatinine was 0.8 mg per 100 ml. Serum antinuclear antibodies were found. Serum complement was decreased at 32.5 mg per 100 ml. Both single stranded and double strand anti DNA antibodies were present in the serum at a titer of 1:32 and 1:8 respectively. The hematocrit was 34% with the direct Coombs test being moderately positive. A percutaneous renal biopsy was

performed and revealed the typical features of lupus nephritis.

She was treated initially with azathioprine 100 mg per day and prednisone 90 mg per day. The dose of prednisone was gradually reduced and changed to alternate day dosage. Triamcinolone 0.1% skin ointment was used for the malar rash. As she became hypertensive on these medications with blood pressure up to 174/130 mm Hg. Moderate salt restriction in the diet and therapy with hydrochlorathiazide, propranolol, and hydralazine were required.

As proteinuria and microhematuria persisted with 20 to 40 RBC per hpf and as her serum complement remained depressed at 61.5 mg per 100 ml, cyclophosphamide at a dose of 125 mg per day was substituted for azathioprine in October 1975. Prednisone was continued at the same dose. By June 1976 the patient had shown significant improvement. The facial rash had almost disappeared. Serum complement was now normal at 145 mg per 100 ml. Urine sediment under the microscope showed an occasional red blood cell only and daily protein excretion in the urine was only 370 mg.

Discussion

A carefully obtained history and physical examination are essential in the evaluation of a child with hematuria. The occurrence of hematuria one to two weeks after a group A beta hemolytic streptococcal pharyngitis or impetigo suggests acute poststreptococcal glomerulonephritis.[2] Recurrent gross hematuria concomitant with upper respiratory infections, in an otherwise healthy child, raises the possibility of benign recurrent hematuria.[3] Hematuria or deafness in another family member may be found in children with chronic hereditary nephritis.[4]

Hypertension and edema present transiently in patients with acute poststreptococcal glomerulonephritis; they are seen occasionally in the course of chronic hereditary nephritis[4] but are rarely encountered in children with benign recurrent hematuria. A malar skin rash is classic in lupus erythematosis; a purpuric skin rash involving the lower extremities, buttock or back with or without accompanying joint involvement strongly suggests Henoch-Schoenlein purpura.[5]

Table 1 includes the mandatory and optional tests suggested in the evaluation of hematuria. Renal parenchymal diseases commonly presenting with hematuria include the following:

- Acute poststreptococcal glomerulonephritis
- Benign recurrent hematuria or Berger's IgA nephropathy
- Hereditary nephritis or Alport's syndrome
- Henoch-Schoenlein purpura nephritis
- Hemolytic-uremic syndrome
- Membranoproliferative glomerulonephritis
- Lupus glomerulonephritis

Table 1—Evaluation of hematuria

TEST	INDICATION
A. Mandatory Tests	
1. Examination of freshly voided urine	Smoky brown urine free of clots or presence of red cell casts indicates renal parenchymal disease
2. Urine culture	Infection
3. Renal function tests BUN, creatinine	Renal functional impairment
4. ASO titer, Streptozyme, Throat culture	Preceding streptococcal infection
5. Serum complement	Decreased in acute poststreptococcal, membranoproliferative, or lupus glomerulonephritis
6. Intravenous pyelogram	Rare anatomic causes: tumors, polycystic kidneys, hydronephrosis, structural anomalies, or stones
7. Hematological tests: Hemoglobin, blood smear, platelets	Anemia, abnormal red cell morphology, and bleeding disorders such as hemophilia *or* von Willebrand's disease
B. Optional Tests	
1. Quantitative urinary protein, serum albumin, cholesterol	Proteinuria on paperstrip indicator (>2+)
2. Fluorescent antinuclear antibody profile	Suggestion of lupus by history and examination
3. Cystoscopy	Gross reflux by IVP or bright red hematuria
4. Renal biopsy	Equivocal diagnosis of probable intrarenal etiology
5. Audiogram	Suggestion of familial nephritis

Acute Poststreptococcal Glomerulonephritis

The patient is usually 3 to 10 years old, more often a male, who develops gross hematuria, hypertension and edema 7 to 14 days after a group A beta hemolytic streptococcal infection. Either streptococcal pharyngitis or skin infection may be responsible.[2,6] The course is one of acute oliguria followed by a diuresis in one to two weeks. The most serious complications are hypertensive encephalopathy, hyperkalemia, congestive heart failure and rarely anuria.

Laboratory investigations reveal moderate to severe hematuria with red cell casts and elevation of the blood urea nitrogen and creatinine. Mild proteinuria (usually less than 1 gm per 24 hours) and less frequently, the nephrotic syndrome may occur.[2,6] Documentation of a previous streptococcal infection should be obtained from throat or skin cultures and elevated ASO or streptozyme titers. A low Beta 1-C globulin or third component of complement (C_3) occurs in 72% to 95% of cases during the acute phase, returning to normal in four to

eight weeks.[7,8] Although macroscopic hematuria clears in six weeks, most cases have microhematuria for 12 months or longer. Further, during the recovery phase, gross hematuria may recur after an upper respiratory tract infection, but these relapses do not cause impairment of renal function or lowering of C_3.[9] Treatment is largely symptomatic: rest during the acute phase, low salt diet, and fluid restriction for edema and oliguria; antihypertensive agents for hypertension, and a 10-day course of penicillin for the eradication of beta hemolytic streptococci present on throat culture. It is seldom necessary to restrict the child's activity for more than two weeks. Full activity should be permitted despite persistent (or recurrent) hematuria.

Benign Recurrent Hematuria (IgA Nephropathy of Berger)

The association of idiopathic recurrent macroscopic hematuria and focal glomerulonephritis with a benign course in children has been recognized since 1914.[10] In 1967 Berger found that this nephropathy is characterized by the presence of glomerular mesangial cell deposits containing IgA, IgG, and C_3.[11] This disease most commonly affects boys between 6 and 12 years with hematuria occurring shortly (usually within two days) after an upper respiratory or other viral infections; following exercise, drug ingestion, or tonsillectomy. Hematuria lasts 3 to 15 days and interval between recurrences varies between 10 days to two years. Hypertension is rare and transient.[12]

Laboratory studies reveal mild proteinuria (less than 1 gm per 24 hours and normal renal function, but cases with transient azotemia have been described. Between attacks the urine is clear or may show variable amounts of hematuria or proteinuria. Serum IgA levels have been elevated, and skin biopsies have demonstrated immunoglobulin A deposition.[13] There is no specific treatment and no restrictions of diet or activity should be imposed during the episodes of hematuria.

Henoch-Schoenlein Purpura Nephritis

Renal involvement in Henoch-Schoenlein purpura is common, with a 20% to a 90% incidence in various series.[5,14,15,16] Renal manifestations almost invariably follow the other symptoms and are thus easily distinguished from other causes of glomerulonephritis, if the diagnosis is considered at the onset of the disease. Its appearance peaks during the late winter and early spring months and the age distribution is between six months and 16 years.[5] 75% of the cases are under seven years. Two thirds of patients have a history of a preceding upper respiratory infection. Of those with renal involvement, gross hematuria occurs in 40% and 60% have microscopic hematuria.[4,14,15] Proteinuria is present in 70%. The extent of proteinuria is an index to the severity of renal involvement: a 24-hour urine protein excretion

Table 2

DISEASE	SALIENT CLINICAL FEATURES	LABORATORY	RENAL BIOPSY
Acute poststreptococcal glomerulonephritis	1-2 weeks preceding beta-streptococcal infection. Transient hypertension, edema, oliguria	Increased ASO, streptozyme and + throat or skin cultures, increased BUN, Cr, depressed C_3	Acute exudative, crescentic proliferative glomerulonephritis
Benign recurrent hematuria	Recurrent hematuria with concomitant upper respiratory or viral infections	Increased serum IgA in some	Increased glomerular mesangial deposition of IgA, IgG and complement
Henoch-Schoenlein purpura nephritis	Skin, joint and abdominal symptoms preceding renal involvement	Increased serum IgA in some	Focal proliferative crescentic glomerulonephritis — with glomerular IgG, IgA + fibrin deposition
Hereditary nephritis	Hearing loss in patient or family member; evidence of other congenital anomalies	High frequency neurosensory hearing impairment	Interstitial foam—cells basement membrane changes on electron microscopy
Membranoproliferative glomerulonephritis	Insiduous onset of anemia, chronic renal insufficiency in preadolescent and adolescent girls	Anemia out of proportion to impairment in renal function, low complement levels	Diffuse mesangial and endothelial hypercellularity. Thickening of glomerular basement membrane
Systemic lupus erythematosis	Arthralgia, rash, pleuritis, fever, lymphadenopathy and cerebritis usually in adolescent girls	Anemia, leukopenia, depressed complement, and single and double stranded DNA antibodies	Variable focal proliferative, membranous and diffuse proliferative glomerulonephritis
Hemolytic-uremic syndrome	Preceding gastroenteritis or viral respiratory illness in a patient with microangiopathic hemolytic anemia, oliguria, thrombocytopenia	Fragmented red cells and helmet cells on peripheral smear. Coombs negative anemia, thrombocytopenia, hyperlipidemia	Renal arteriolar fibrin deposition with luminal obliteration by fibrin thrombi

of between 0.2 gm and 0.5 gm is considered as minimal nephritis, between 0.5 and 2 gm as moderately severe nephritis, and over 2 gm protein excretion as severe nephritis.[14] The nephrotic syndrome, azotemia, hypertension, and oliguria may be seen in those with severe nephritis, who comprise about 5% of all patients with renal involvement. Persistence of urinary findings beyond four weeks is an indication for careful followup. After a two-year followup period 70% of these cases are completely recovered. Thirty percent are asymptomatic, but have mild hematuria and proteinuria. Those patients with the fulminant clinical and histopathological picture usually develop chronic renal insufficiency.[14] No specific laboratory test is diagnostic, although elevated IgA levels have been found in some cases. No treatment is indicated for mild or moderate cases. However, those with persistent urinary abnormality should be followed closely for early detection of hypertension and renal insufficiency. Apparently steroids alone are of no benefit. There is controversy concerning the use of immunosuppressive agents.[14]

Hereditary Nephritis

A family history of either nephritis, hearing loss or abnormal urinalysis inherited in an autosomal dominant fashion is suggestive of Alport's syndrome.[4] Hematuria is usually recurrent, primarily in preadolescent or adolescent boys after an upper respiratory infection or acute febrile illness. Affected girls have a more benign course. High frequency neurosensory hearing loss may be present before symptoms of kidney disease appear. Other congenital anomalies have been reported, including: ocular defects, such as cataracts, lens opacities, keratoconus, and severe myopia combined with retinopathy; cryptorchidism, inguinal hernia, and renal anomalies; spina bifida; and pectus excavatum.[4]

No specific laboratory tests are diagnostic. A urinalysis of the patient, his parents and siblings should be performed. The urinalysis usually shows proteinuria, casts and white cells. An audiogram demonstrating the characteristic hearing loss in association with hematuria makes the diagnosis of Alport's syndrome almost certain. A renal biopsy is not mandatory, but in atypical cases may be helpful.

The course is that of slow progression to renal failure over several years. Successful renal transplantations have occurred with both living related donors and cadaveric-kidneys.

Membranoproliferative Glomerulonephritis (Mesangiocapillary, Hypocomplementemic Glomerulonephritis)

Hematuria can be caused by membranoproliferative glomerulonephritis, an entity with distinct clinical, immunological, and morphological features that accounts for approximately 25% of cases of chronic glomerulonephritis.[17] This disease is more common in girls, usually over eight years of age. No distinct link with upper respiratory tract infection has been found. Hematuria is present in 75% of cases with gross hematuria seen in 33% on initial presentation.[18] The nephrotic syndrome is seen in 67% of cases, often a mild form. Azotemia, hypertension, and anemia out of proportion to the degree of renal functional impairment are commonly found. Renal failure evolves slowly over many years with periods of spontaneous remissions and exacerbations. There is approximately a 50% mortality rate by the eleventh year of disease.[17] The prognosis is worse in those with the nephrotic syndrome, macroscopic hematuria, initial azotemia, or epithelial crescents on renal biopsy. Hypocomplementemia is seen in two thirds of cases. This entity also has been associated with a circulating serum factor (C_3 nephritic factor) and with activation of complement presumably through an alternate pathway.[19] No clear benefit has been shown by various treatment modalities including steroids, azathioprine, cyclophosphamide, indomethacin, or anticoagulants.

Systemic Lupus Erythematosis (SLE)

This protean disease is most common in adolescent girls and presents with various combinations of anemia, leukopenia, arthralgias, rash, pleuritis, pericarditis, fever, lymphadenopathy, vasculitis, and cerebritis. The classical urinary finding is said to be "telescopic urine" containing red cells, white cells, protein, red and white cell casts, and waxy casts.[20] Hematuria rarely appears alone or as an initial presentation. The diffuse systemic clinical presentation of SLE should prevent confusion with other renal parenchymal causes of hematuria.

Three renal pathologic findings are demonstrable in renal biopsy specimens: focal glomerulonephritis, membranous nephropathy, and diffuse proliferative glomerulonephritis. IgA, IgG, and C_3 are found by immunofluorescent microscopy.[21] At present there is some controversy about the use of immunosuppressive agents in addition to steroids in this serious disorder.

Hemolytic Uremic Syndrome (HUS)

An acute onset of microangiopathic hemolytic anemia, nephropathy, and thrombocytopenia following gastroenteritis, or viral respiratory illness is suggestive of HUS.[22] Infants and young children are usually affected. Gastroenteritis occurs for periods up to three weeks and may demonstrate bloody diarrhea suggestive of ulcerative colitis, or be associated with severe abdominal pain that is confused with acute appendicitis. The usual presenting symptoms include bleeding into the skin, urinary or gastrointestinal tract; pallor; and oliguria. On examination, the association of hypertension and pallor in an oliguric patient with the history of diarrhea and dehydration would favor HUS. Other manifestations include congestive heart failure with peripheral edema, pulmonary edema, venous congestion, and hepatomegaly.[23] Jaundice and splenomegaly may be seen. The course is variable with mild cases showing gradual improvement in one to two months and severe cases progressing to terminal renal insufficiency in two to

six months. Poor prognosis has been associated with age greater than 18 months, a need for over six transfusions, persistent leukocytosis, more than three days of anuria, the reappearance of hemorrhagic phenomena after the 10th day of the illness and the late onset of neurologic signs.[23]

Laboratory findings include an abnormal peripheral blood smear with fragmented red cells, which are helmet-shaped or have spur-like projections. The anemia is characterized as being Coombs-negative with reticulocytosis and indirect hyperbilirubinemia. Thrombocytopenia usually occurs without other alterations of clotting factors. There may be hyperlipidemia involving triglycerides, cholesterol and phospholipids. BUN and creatinine are elevated. Proteinuria is mild, ranging from 1 to 2 gm in 24 hours. Several modes of therapy have been tried including anticoagulation, immunosuppression, and fibrinolytic therapy, but none has proved effective. Early peritoneal dialysis is helpful in severe cases.[23] Careful attention to the management of oliguria, electrolyte disorders, acidosis, hypertension, and fluid overload as well as the anemia and thrombocytopenia is essential.

These diseases comprise the common causes of recurrent hematuria in children. A careful evaluation of clinical and laboratory features can often lead to a diagnosis in individual cases, thus permitting an understanding of the ultimate prognosis.

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ABSTRACT Wisconsin Authors

Paraganglioma Simulating Primary Rib Tumor

John J Smalley, MD; William B Gallagher, MD; and Charles P Nichols, MD, LaCrosse, Wis: *Arch Surg* 112:323-325 (Mar) 1977

Nonchromaffin paragangliomas (chemodectomas) have been reported from a wide variety of sites, generally in anatomic proximity to the known chemoreceptor organs. Thus, the more common tumors have been reported occurring in the carotid body and glomus jugulare. Those neoplasms occurring in the thorax have been located generally in the mediastinum in anatomical apposition to the normally occurring chemoreceptor bodies. We report an unusual case of a nonchromaffin paraganglioma presenting clinically in the thorax of a seven-year-old girl which was located more eccentrically and mimicked a primary rib tumor. To our knowledge, this is the first report in the literature of a paraganglioma in this location.

The clinical presentation, radiographic appearance, and subsequent surgical therapy consisting of incontinuity resection of the involved chest wall and the middle lobe of the right lung were presented. The patient's postoperative course was uneventful, and follow-up after four and one-half years revealed no recurrence.

It is proposed that the tumor arose in an embryonic rest of ganglion cells associated with the fourth intercostal nerve. The relationship of nonchromaffin paragangliomas to alveolar soft part sarcomas is mentioned. Histologic criteria such as cellular variation or mitotic figures do not correlate well with the clinical behavior of the tumors, and if one accepts the presence of histologically proven metastases as the only *sine qua non* of malignancy, then the vast majority of these tumors are benign. ■

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Tuberculosis

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MODERN CHEMOTHERAPY of tuberculosis (TBC) is highly effective. When therapy is properly applied, a successful result is expected in more than 95% of cases, an experience that equals or surpasses the record in any other infectious disease and far surpasses the results in most chronic diseases. While chemotherapy has been the cornerstone of this success, our increased understanding of the natural history, manner of spread, and epidemiology of TBC also has played a major role in the approach to effective management.

Tuberculosis is transmitted by airborne droplet nuclei from an infected host by person to person contact as in coughing, singing, or speaking, and only rarely by any other means.[1] Most droplet nuclei, if inhaled, will be trapped in the upper airways or on the mucous blanket of the larger airways where they will be harmlessly cleared. It is only those few that reach and deposit in the terminal air spaces that are capable of producing infection. In early stages of infection bacilli multiply in the absence of a host response. At this time spread of infection through lymphatic and hematogenous routes occurs. Eventually, in about three to eight weeks specific cellular immunity develops which checks the infection, and this phase is marked by the appearance of tuberculin reactivity. In most cases the disease ends here, but in a few, the host defenses are imperfect and the disease continues to progress (progressive primary infection) or more commonly enters a dormant phase only to reactivate years later when host defenses are altered by alcoholism, malnutrition, or intercurrent disease (chronic adult type or reactivation infection).[2]

We recognize that the usual adult form of TBC occurring sporadically represents endogenous reactivation of a dormant focus of infection acquired years previously and that contacts of a contagious case who show evidence of recent infection by conversion of their tuberculin reaction are a high risk group. These concepts and a declining incidence have resulted in a shift of approach to both case finding and the disease itself.

Mass x-ray screening has been abandoned and emphasis is now placed more narrowly on investigation of persons who are already infected: the tuberculin reactor, especially the one with recent conversion or contact with an infectious case or one with additional risk factors such as abnormal x-ray films, previously untreated but stable tuberculosis, or complicating medical problems such as alcoholism, diabetes, malignancy, silicosis or ulcer disease.

As a result of these advances in understanding and therapy, the case rate, duration of hospitalization, and death rate have declined steeply and steadily over the past several decades.[3] Indeed the incidence of tuberculosis is now low enough so that our unfamiliarity with manifestations of those less common forms such as extrapulmonary and miliary disease may result in failure to consider tuberculosis in the differential diagnosis. However, once tuberculosis is recognized and treatment begun, the results are quite impressive. Symptoms begin to improve over days and continue to improve over weeks. X-ray films show reversal of the exudative infiltrates but not the shadows representing destroyed tissue. Contagiousness is rapidly reversed so that after a brief period on chemotherapy the average case is no longer able to transmit the disease even if the tubercle bacillus is still detectable in his sputum.[4,5]

For all practical purposes only those cases who show numbers of acid-fast bacilli on sputum smear are in a contagious state. After therapy is begun, contagiousness rapidly declines, and this can be gauged by serial weekly sputum smears. When the smears show only few or sparse AFB, often within one to two weeks of treatment, the patient can be discharged to clinic. Consequently, hospitalization is needed only during the initial phase of diagnosis and treatment, and the more modest cases often can be

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handled entirely as outpatients. Prolonged hospitalization is reserved only for those who actually remain ill, and the real focus of treatment is usually the clinic,[6,7] where most of the investigations, treatment, and education are delivered. Education should not be slighted as the patient must understand his disease in order to cooperate for long-term therapy. The desired result is a minimum period of disability and the patient's rapid return to work and other activities.

Along with prolonged hospitalization, resectional surgery also has been abandoned. Surgery is now limited to such special problems as establishing a diagnosis especially when malignancy is a consideration, drainage of empyema, or relief of constrictive pericarditis.

The principles of chemotherapy remain unchanged from what they were two decades ago: Maximal success depends upon (1) combination of effective drugs (2) regular uninterrupted use, and (3) adequate duration of treatment. The details have changed in the search for the strongest, most rapidly effective, and acceptable regimen with minimum untoward effects, reasonable cost, and shortest necessary duration of treatment to produce long-term "cure."*

Isoniazid (INH) continues to be the cornerstone of treatment, and rifampin (RFN) has shown itself as a companion drug of nearly equivalent potency.[10] Our standard treatment is INH 300 mg and RFN 600 mg in a single daily dose for 6 to 12 months, then INH alone for a total of 18 to 24 months. In extensive disease as when cavitation is present or in most extrapulmonary forms, a third drug is used during the initial 6 to 9 months. We generally use ethambutol (EMB) because it is well tolerated and reasonably effective. EMB is given 15 mg per kg, but we prefer to use a higher dose of 25 mg per kg for the first six weeks. This phased reduction in drugs as the infection regresses is as effective as continued use of all drugs for the entire duration of treatment.[3] Routine monitoring of blood count, SGOT, and color vision and acuity is advised on a monthly basis for the first several months of treatment because of the possible but infrequent side effects of hepatotoxicity, anemia, thrombocytopenia, and, with EMB, optic neuritis. Pyridoxine may be given to prevent INH-induced neuropathy, and several INH preparations incorporate pyridoxine in each tablet.

Streptomycin (SM) while more effective than EMB is less acceptable because of the required parenteral route and serious side effects of vestibular toxcity, nephrotoxicity, or hypersensitivity reactions in 10 to 15 percent of cases. It is substituted or used when needed, especially in the more seriously ill case when peroral absorption is uncertain, or in supervised intermittent treatment described below.

"Tuberculosis cases are dwindling in number, but the consequences of missed diagnosis or inadequate treatment are still often tragic when proper treatment can offer reliably good results."

Isoniazid (INH) used alone for 12 months is recommended for prophylaxis for the tuberculin reactor with additional risk factor of (1) recent conversion of skin test, (2) known recent contact with a contagious case, (3) abnormal x-ray film indicative of "dormant" or stable tuberculosis foci or with previously known but untreated TBC, (4) additional medical risk factors such as silicosis, neoplasm especially lymphoma, diabetes, and the like. Exclusion of a more extensive or active stage by review of old x-ray films or sputum cultures is often important in these cases since a single drug would be inadequate for treatment of more extensive disease. The mass use of INH for all reactors has been abandoned because the risk of hepatotoxicity outweighs the risks of TBC particularly over age 35 unless additional risk factors are present.[11]

New approaches to treatment other than the standard 18 to 24 month daily course have met with success. These are supervised intermittent therapy and short course therapy. The former consists of an initial phase of daily treatment followed by high dose treatment *administered in the clinic* usually twice weekly. The obvious advantage is that it insures that drugs are actually taken. It has been especially useful in this country in programs dealing with unreliable patients; *ie,* the alcoholic who so often cooperates poorly if at all.[12] Short course therapy consists of vigorous treatment, usually three drugs, for a total of 6 to 9 months. The major advantage here is that patient compliance is improved because his attention span is not unduly taxed, and the treatment can be delivered reliably but more cheaply and simply. The appeal of these simpler approaches has been greatest in developing nations where cost is often a crucial factor. Several of the trials in Asia and Africa conducted by the British Medical Research Council[13] have attained excellent longterm results while relying mainly on INH, SM, and pyrazinamide (PZA) but without the advantages of RFN and EMB. Recent reports from Britain[14] and France[15] indicate that a 9-month course of INH-RFN supplemented initially by EMB or SM are as effective as an 18 to 24 month program. Moreover it appears that RFN, which is costly, need not be given for the entire period, and that introduction of PZA to this combination can shorten the course even further with full effectiveness.[16]

Another chemotherapeutic advance is matrix or slow release INH. This form of INH has not yet been approved for use, but it promises improved results in intermittent

*The cautious phthisiologist traditionally spoke of "arrest" of tuberculosis anticipating a recurrence in a fair number of cases. With current therapy, the long-term results have proved so uniformly good that "cure" is a realistic term and patients can routinely be discharged from follow-up after one to two years' observation following completion of treatment.[8,9]

dose programs especially in those populations where rapid metabolic inactivation of INH is present.

These refinements in therapy are very encouraging. I am sure that short course and supervised intermittent regimens will be our standards in the near future. Tuberculosis cases are dwindling in number, but the consequences of missed diagnosis or inadequate treatment are still often tragic when proper treatment can offer reliably good results.

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ABSTRACTS Wisconsin Authors

Circulating Basophils in Normal Subjects and in Subjects with Hay Fever

S Roger Hirsch, MD and John H Kalbfleisch, PhD, Milwaukee, Wis: *J Allergy Clin Immunol* 58:676-682 (Dec) 1976

The relationship of hay fever symptoms and changes in the number of circulating basophils was studied in 12 subjects clinically sensitive only to ragweed and in 10 nonatopic subjects before, during, and after the ragweed season. Total white blood counts, absolute basophil counts, and symptom scores were recorded twice weekly from mid-June through October 1974, and compared with the ragweed pollen count. The results indicated that the absolute and relative number of basophils were significantly elevated ($p<0.001$) in the hay fever group when symptoms occurred. As the symptom score of the allergic group increased during the ragweed season, the number of basophils also increased, only to decrease to control values when symptoms subsided. The basophil counts of the atopic group were significantly higher than those of the nonatopic group during the control periods. The nonatopic group also showed a significant elevation of basophils during the ragweed season, but to a much lesser extent than the atopic group. It is concluded that: (1) subjects with symptomatic hay fever have a significantly elevated absolute and relative basophil count which correlates with the exacerbation and remission of symptoms; (2) nonatopic subjects also have a small but significant elevation of basophils during the ragweed season; and (3) the elevation of basophils in the atopic group during symptoms is significantly greater than in the nonatopic group during the ragweed season. ■

Chemosurgery for Melanoma

Frederic E Mohs, MD, Madison, Wis: *Arch Dermatol* 113:285-291 (Mar) 1977

Like basal and squamous cell carcinomas of the skin, melanomas also often send out unpredictable ramifications for some distance beyond the visible and palpable borders of the neoplasm. The eradication of these silent outgrowths is ensured by the microscopically controlled excisions that characterize the chemosurgical method. However, because of the strong tendency of melanoma to invade vascular walls and hence to metastasize frequently, the chemosurgical technique differs from that used for carcinoma in two ways.

First, the tissues always are chemically fixed in situ before any incisions are made in order to minimize the chance of dissemination, and second, an extra margin of tissue is removed after reaching a melanoma-free plane in order to encompass possible outlying melanomatous satellites in the peritumoral lymphatics.

In a series of 103 cases of melanoma there were only three recurrences in the primary site. One of these died of coronary occlusion during chemosurgical re-excision of a focus in an area of melanosis in the conjunctiva, the other two were re-excised chemosurgically and had no further recurrence in 18 years.

The five-year cure rate in the series of 103 cases was 50 percent which is a high rate for a series in which 69 percent were of the most dangerous nodular type of melanoma and 64 percent had invaded to the subcutaneous tissue (Clark's level V).

The advantages of chemosurgical excision are (1) reliability because there is no danger of disseminating melanoma cells by transecting unexpected outgrowths or peritumoral satellites and there is no tendency for the operative procedure to cause metastatic spread; (2) flexibility because the initial excision provides microscopic determination of whether or not the pigmented lesion is actually melanoma and provides information concerning the degree of malignancy which aids in determining the extent of the excision and in assessing the need for prophylactic dissection of the regional nodes; (3) conservatism of a degree that would be unsafe with excision without complete microscopical control; (4) low operative risk because no general anesthesia is needed and the patients remain ambulatory during treatment; (5) good healing by granulation; and (6) extension of operability to patients with extensive melanomas in difficult sites where surgical excision might not be feasible.

Physicians, and also laymen, are becoming more aware of the importance of early recognition and treatment of melanomas with the result that the rates of cure are steadily improving. ■

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EDITOR: Luis B Curet, MD, Professor, Department of Gynecology-Obstetrics, University of Wisconsin Center for Health Sciences-Madison General Hospital, Madison, Wisconsin

SINCE THE ADVENT of RhoGAM® [Rh_0 (D) immune globulin (human)], the average practicing obstetrician has become underexposed to the problem of isoimmunization. The emergence of regionalization of perinatal care has further reduced the exposure. As previously held concepts about management of the Rh negative pregnant patient have changed quite dramatically over the past few years, it is timely to have a short review of the subject with emphasis on the more important concepts. The following article attempts to do so, realizing that in this limited space, one cannot do justice to such a complex problem.

Obstetrical Management of Rh Negative Pregnancies

Perry A Henderson, MD, Madison, Wisconsin

In 1968, Rh immunoglobulin became available for use in non-sensitized Rh negative women. However, there is a generation of women, still in their reproductive years, who already are sensitized. Therefore, it seems timely to review some of the problems which arise in managing Rh negative pregnancies and place them in the perspective of today's medical care.

A. Serological Tests

Screening for antibodies against the Rh_0(D) antigen as well as other "irregular" antibodies should be performed routinely. Such antibody screening, if positive, should be followed by identification of the specific antibodies and a quantitative antibody titer.

There are two issues which must be considered.

(1) Irregular antibodies as well as antibodies to the Rh_0 (D) antigen can cause hemolytic disease of the newborn.

(2) A negative cross-match procedure prior to a blood transfusion does not prevent a patient from receiving an antigen in that transfusion and subsequently becoming sensitized. With the increasing use of blood transfusions in modern medicine, this type of stimulation of antibodies is becoming more common.

B. Amniocentesis

In the early 1960s it was demonstrated that analysis of amniotic fluid for bilirubin was more reliable than maternal antibody titers in assessing the intrauterine condition of the fetus. However, the concept of a "critical titer" has evolved. This titer is that antibody level below which amniocentesis is not indicated because there have been no stillbirths or severely affected infants. This must be established by each laboratory in conjunction with the clinicians. This critical titer is usually 1:16.

In addition with a bloody tap there is concern for feto-maternal transfusion of Rh positive cells with subsequent increase in sensitization and contamination of the amniotic fluid with blood which could interfere with subsequent interpretation of amniotic fluid analyses.

Complications of amniocentesis can be minimized by utilizing ultrasound localization of the fetus and placenta prior to the procedure. Ultrasound may also contribute additional diagnostic information with respect to the fetus, like detection of hydrops. Should blood be obtained in amniocentesis, its source should be determined immediately by an Apt test for fetal hemoglobin.[1]

C. Gestational Age Determination

The management of Rh sensitized pregnancies is especially dependent upon the accurate assessment of gestational age since the bilirubin content of amniotic fluid normally decreases as pregnancy progresses. For example, a delta O.D. of 0.20 at 29 weeks would place the patient in Zone 2; whereas, if the gestational age is 33 weeks, this same delta O.D. would place the patient in Zone 3.

D. Delta O.D. Interpretation

The delta O.D. at 450 mu is di-

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rectly related to the severity of the hemolytic process in the fetus. However, it may be distorted if the amniotic fluid is contaminated with either fresh or old blood. Once a bloody amniocentesis is obtained, consideration should be given to evaluating the amniotic fluid after performing a chloroform extraction of the bilirubin.[2]

E. Guidelines for Rh Immunoglobulin Prophylaxis

Most Rh sensitization follows the delivery of an Rh positive infant by an Rh negative woman. To prevent sensitization the mother should receive Rh immunoglobulin if she is non-sensitized and if the infant has a negative direct Coombs test. If the Coombs test is positive, but is due to an antibody other than $Rh_o(D)$, the immunoglobulin should still be administered.

Rh sensitization also can occur after an abortion. Therefore, it is imperative that all Rh negative women receive Rh immunoglobulin prophylaxis following an abortion. The fetus under these conditions is presumed to be Rh positive.

Ectopic pregnancy can be the source of fetomaternal transfusion sufficient to cause Rh sensitization. Therefore, all Rh negative non-sensitized women who have a documented ectopic pregnancy also should be protected with Rh immunoglobulin prophylaxis. Passive immunization with Rh immunoglobulin is a transient phenomenon and must be repeated with each pregnancy, abortion or ectopic pregnancy.

One vial or 300 μg of Rh immunoglobulin is the usual dose. This is sufficient to negate the effect of a fetomaternal transfusion of 30 ml of whole blood or 15 ml of packed cells. Fetomaternal transfusions may be minimal (1-2 ml) or massive (50-200 ml). This latter may occur with Cesarean sections, abruptio placenta, and manual removal of the placenta. When massive transfusions are suspected, an effort should be made to quantitate the amount transfused and then administer an appropriate dose of Rh immunoglobulin. Kleihauer-Betke smears of maternal blood have been used to quantitate fetomaternal transfusion, and one of the drug companies has recently produced a kit which utilizes a modification of this technique.*

Finally, the question is commonly being asked whether Rh immunoglobulin should be administered to the Rh negative non-sensitized pregnant woman following an amniocentesis in which blood is obtained. The effect on the fetus of administering Rh immunoglobulin in such instances has yet to be demonstrated. Henry[3] recently published a series of 56 patients who received Rh immunoglobulin following amniocentesis during the second trimester. One case of sensitization occurred and there were no problems detected in the infants which could be ascribed to the Rh immunogobulin. Although several other investigators are advocating this approach, more data are necessary before it can be routinely advocated.

*Ortho's Fetaldex®.

F. Regionalization of Obstetric Services

Regionalization of obstetric services is becoming more common and Rh disease is a classic example of a clinical entity which can best be managed within this frame of reference. Rh sensitization is becoming less common. It is unrealistic to expect a clinician who sees only an occasional sensitized patient to be fully knowledgeable of the many perspectives described in this paper. On the other hand, a tertiary center, drawing from a large delivery base, will have a population of sensitized patients sufficient to maintain the clinicians' management skills.

The management of patients with Rh sensitization can best be accomplished in a "perinatal center." Many of the decisions necessary can best be made when there is team cooperation and an evolved protocol. For example, when is it best to deliver the patient rather than perform an intrauterine transfusion? Depending upon how many prenatal intrauterine transfusions are given, should blood given to the neonate be a packed cell transfusion or an exchange transfusion? Does the percentage of fetal versus adult hemoglobin in the cord blood influence the type of transfusion to be given? How does the presence of fetal hydrops alter these decisions? Obstetrical and neonatal communications are essential for the optimal management of these patients and this cannot really be accomplished on a once or twice-a-year basis. It must be an inherent part of a smoothly functioning perinatal team. The tertiary perinatal center, with its regional referring pattern, offers us an opportunity to eliminate Rh disease as a significant cause of infant mortality and morbidity.

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ABSTRACT

Wisconsin Neurological Society

Recurrent Guillain-Barre Syndrome: Case Report

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Presented at the Spring Meeting of the Wisconsin Neurological Society, May 30-31, 1975, in Oshkosh, Wis

A 72-year-old retired businessman had four distinct attacks of polyneuritis following mild respiratory infection. The recurrences occurred over a 54-year time span with more or less complete recovery each time. This is a relatively rare phenomena and probably occurs in less than 4 percent of all cases of Guillain-Barré polyneuritis. ■

Rehabilitation of the angina patient with atrial fibrillation

Report of two cases with good therapeutic response to beta adrenergic blockade and an exercise regimen

Robert T Obma, MD
Philip K Wilson, EdD
LaCrosse, Wisconsin

• **Two patients with refractory atrial fibrillation and angina pectoris were treated with propranolol to slow the inappropriate chronotropic response to exercise followed by an exercise reconditioning regimen. The combination resulted in a doubling of angina-free exercise capacity.**

TWO MEN WITH refractory atrial fibrillation had stable exertional angina pectoris on digitalis treatment. Addition of propranolol to the regimen increased symptom free exercise tolerance and permitted them to undertake a walking regimen which resulted in a further increase in symptom-free exercise tolerance. Patients with chronic atrial fibrillation and angina pectoris limitation are infrequently seen in the cardiac exercise laboratory (2 in 1352 exercise evaluations in our laboratory). It is unlikely that any one center will accumulate a series of such patients and the doubling of angina-free exercise capability was so dramatic as to be worthy of report.

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Case reports

Case 1. A 72-year-old retired school teacher was seen in consultation at St Francis Hospital in August 1975. He had a two-year history of oppressive precordial pain occurring on exertion relieved by rest or sublingual trinitroglycerin in three to five minutes. He had had atrial fibrillation for two years. No episodes of unstable angina pectoris or myocardial infarction had occurred.

Examination revealed a normotensive elderly male in no distress. The cardiovascular examination was normal except for an irregularly irregular heart beat.

Laboratory findings included a 12 lead resting electrocardiogram showing atrial fibrillation, left axis deviation and nonspecific ST and T wave changes compatible with digitalis effect. Chest roentgenogram was within normal limits. Serum thyroxin was 7.6 μg per 100 ml. Cardioversion was attempted but was unsuccessful.

An exercise evaluation was performed utilizing a modification of the Balke technique[1] with the patient on digoxin, 0.375 mg by mouth daily. Angina pectoris was provoked within three minutes of the patient's reaching the 2.0 mile per hour speed at 0% grade (Fig 1). Resting 1 mm, ST segment depression increased to 3 mm. Therapeutic risks and alternatives were discussed with the patient and he declined surgery.

Propranolol, 40 mg by mouth twice daily, was added to his digoxin regimen and a week later a second exercise evaluation revealed an increase in symptom-free exercise tolerance to 2.5 miles per hour at 0% grade. He became symptomatic at 3.0 miles per hour at 0% grade with cerebral ischemia manifested by light headedness and accompanied by a 15 mm decline in systolic blood pressure (Fig 1). He was instructed to walk at 2 to 2.5 miles in an hour daily on level ground and carried this out faithfully.

Twelve weeks later, he was again evaluated and at this time was limited by musculoskeletal fatigue at 3.4 miles per hour at a 4% grade (Fig 1). Exercise was prescribed for 30 minutes daily at 3.5 to 4.0 miles an hour. He does not want to push beyond this as he feels that a 4.5 mile per hour jogging capacity is adequate at age 72.

Case 2. A 67-year-old retired machinist was seen with a history of acute anteroseptal myocardial infarction in 1963 followed by persistent atrial fibrillation. For the past five years he had had precordial pain on exertion relieved by nitroglycerin in three to five minutes.

Examination revealed a normotensive male with normal heart size, and irregularly irregular heart beat; no murmurs were audible. An electrocardiogram showed residua of the old anteroseptal myocardial infarction and nonspecific ST and T wave changes. Chest roentgenogram was within normal limits. Serum thyroxin was 6.2 μg per 100 ml.

An exercise evaluation (Fig 1) utilizing 3 minute stages was performed with the patient taking digoxin 0.25 mg daily and angina pectoris was provoked at 2.5 miles per hour at 0% grade. Resting 1 mm, ST depression increase to 2 mm. Therapeutic risks and alternatives were discussed with the patient.

Propranolol, 40 mg by mouth twice daily, was added to his exercise regi-

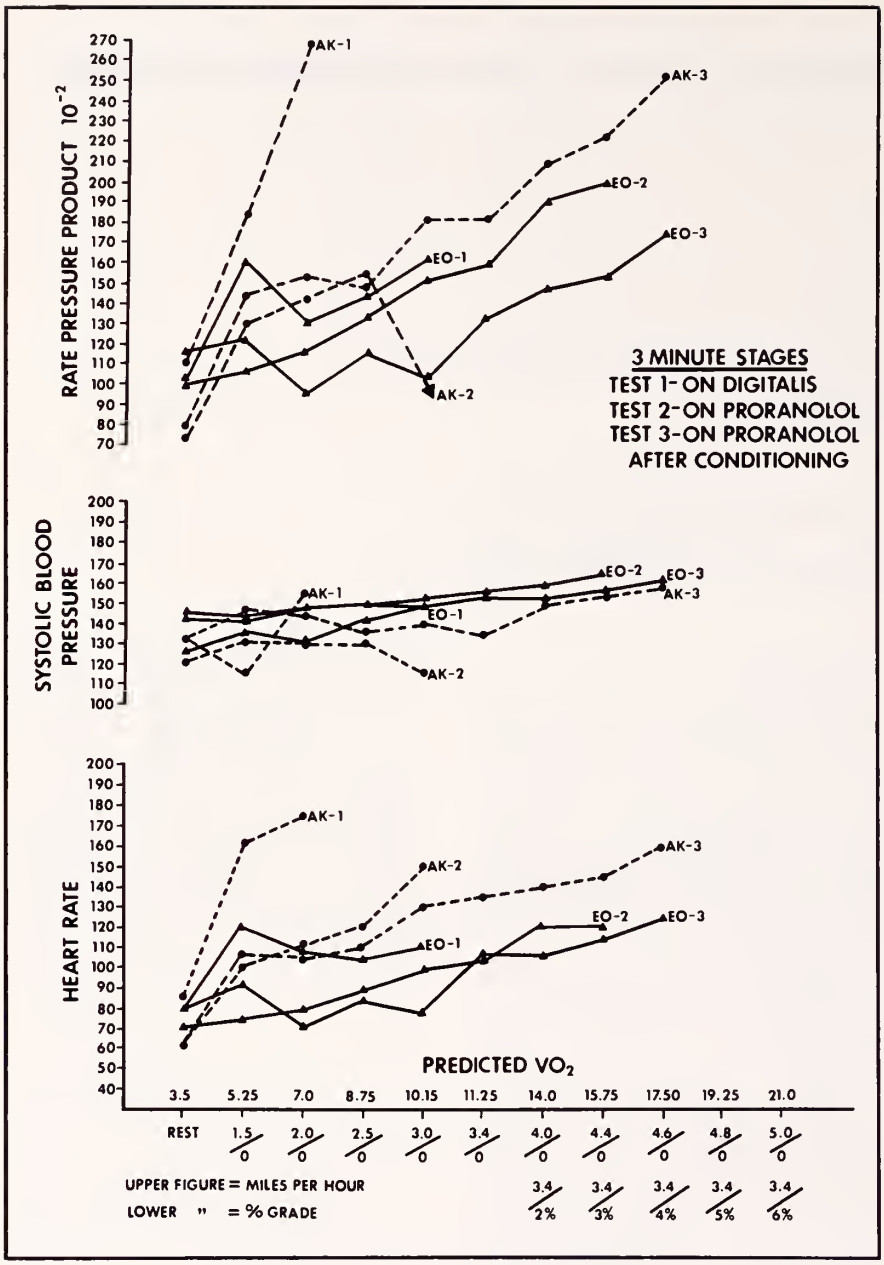

Figure 1

men but he noted a marked decrease in exercise tolerance so this was decreased to 20 mg twice daily and an exercise evaluation was performed after a week (Fig 1). He developed angina pectoris at 3.4 miles per hour 2% grade. He was instructed to walk 3 miles daily in one hour which he did faithfully. Eight weeks later he was exercise tested again (Fig 1) and was limited by dyspnea at 3.4 miles per hour 4% grade.

Discussion

The normal response to a gradual increase in isotonic exercise such as walking consists of the gradual increase in heart rate, systolic blood pressure, stroke volume,[2-5] redistribution of pumped blood to working skeletal muscles,[6] and increased arteriovenous oxygen extraction by skeletal muscle.[7]

The patient limited by exertional angina pectoris has limited coronary blood flow due to his anatomic obstructions.[8] The internal work capacity of the heart can be measured clinically by calculating the rate pressure product of heart rate times systolic pressure at the time of onset of exertional angina pectoris. The rate pressure product is reproducible and is known to correlate closely with oxygen delivery to the myocardium.[9,10] External work capacity is reproducible for a given patient with an exercise protocol with gradual increase in work loads and adequate time periods with each stage of exercise for physiologic equilibration.[11-13]

The peculiarity of the exercise response in atrial fibrillation that puts the patient at greatest vulnerability to angina pectoris is the marked increase in heart rate at low work loads which was seen in these cases.[14-16] This is probably due to facilitation of AV nodal conduction by catecholamines since it can be blocked by propranolol.[17,18]

The second tests after the addition of a beta adrenergic blocking drug shows a more gradual rate increase with increase in exercise level, indeed, the patient in Case 1 was at this time not limited by angina but by inadequate cardiac output relative to the state of vasodilation. The inadequate cardiac output could be attributed to the known inability of the heart to increase stroke volume with tachycardia in atrial fibrillation[16] as well as to his lower attained heart rate. Cerebral ischemia was the limiting factor here before a rate pressure product adequate to provoke angina pectoris was reached. The beta blockade induced slower rate response to exercise has been documented in atrial fibrillation without angina pectoris and known to frequently decrease exercise capacity.[17] After propranolol dose adjustments, both patients enjoyed an increase in asymptomatic external work tolerance which permitted them to embark on the physical reconditioning program with walking.

Physical reconditioning regimens have been known to increase pain-free exercise capacity in angina limited patient from Heberden's time[19] to the present. Mechanisms demonstrated for this are lowering of heart rate and blood pressure for

a given external work load, increased arterial oxygen extraction and increased oxidative enzymes in the leg muscles.[19-23] In the present cases, decreased rate pressure product for a given work load is the only variable that could be measured clinically. Between the clinically measurable variables and the others known to be present, however, external work capacity was substantially increased by the exercise regimen.

Atrial fibrillation and exertional angina pectoris are both common manifestations of coronary occlusive disease. They are probably not seen together in the diagnostic exercise laboratory because the diagnosis is obvious by the time both are present. This case is presented as an encouraging response to a rational therapeutic approach. In such cases propranolol should be initiated at low dosage. Because of the deterioration in exercise capacity seen with doses currently considered moderate for exertional angina pectoris and exercise prescribed precisely, response to therapy should be monitored at each step with an appropriately designed protocol.[8] The reproducibility of these initial encouraging patient cases permits further case evaluations.

Logistics and program availability permitting, a medically supervised program of exercise in a community-based program is preferable for reasons of safety and precision of intensity of exercise treatment.[23] When this is not practical, as in these cases, the low known risk of cardiovascular complications of exercise for patients must be acceptable to physician and patient.[24,25]

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ABSTRACTS Wisconsin Authors

Endolymphatic sac surgery for hearing conservation in Meniere disease

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Arch Otolaryngol 103:268-270 (May) 1977

Thirty-five patients with Meniere disease underwent endolymphatic sac decompression and drainage with a Silastic sac-mastoid shunt. On the basis of patients' responses to a questionnaire and on analysis of preoperative and postoperative audiometric studies, we found the method to be an effective means for conservation or improvement of hearing and for relief of vertigo in patients with positive glycerol tests. Of the 35 patients, 8 had negative glycerol tests and did not benefit from surgery ($P<.001$). Of the 27 patients with positive glycerol tests, 70.4% (19) had no further vertigo, and 18.5% (5) had decreased frequency or severity of attacks (an overall relief of vertigo in 88.9%). Hearing was improved in 16 (59.2%) and stabilized in 5 (18.5%). Subjectively, 85.2% (23/35) of the patients were satisfied with the hearing results of their operation. ■

Tissue estrogen receptor and carcinoembryonic antigen in colonic neoplasms

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Arch Surg 112:240-241 (Mar) 1977

Estrogen receptor protein was found in 24 percent of colonic neoplasms. Presence of estrogen receptor activity was independent of age or sex of the patient, state of differentiation or spread of the tumor, and concentration of carcinoembryonic antigen in the tumor. Estrogen receptor activity in colon tumors probably reflects novel protein synthesis resulting from dedifferentiation. Measurement of tumor estrogen receptor protein and carcinoembryonic antigen may have discriminatory value in the patient with metastatic adenocarcinoma and an unknown primary. ■

Neurogenic intermittent claudication:

Historical background, outline of modern concepts and analysis of 23 cases

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• A historical approach to the understanding of neurogenic intermittent claudication is presented, with an analysis of 23 consecutive cases treated in 1970 through 1975. Failure to clinically recognize neurogenic intermittent claudication, or to appreciate its underlying mechanisms, may result in severe and irreversible damage. The latter may be due to delay in surgical decompression, or to the use of the laterally flexed or hyperlordotic position while the anesthetized patient is undergoing surgical procedures for other coexistent disorders.

RECOGNITION OF neurogenic intermittent claudication is among the duties of any clinician who deals with adult systemic or skeletal disease. Its successful neurosurgical management is well documented in Europe,[1-5] in this country[6-8] and in the Far East.[9] Furthermore, dire consequences may result from failure or undue delay in its diagnosis.[8,10]

The concept of neurogenic intermittent claudication developed historically from the earlier concept of intermittent claudication due to vascular disease. Derived from Latin, the term "claudication" simply means "lameness" or "limping." On October 18, 1831, during a meeting of the Académie Royale de Médecine, Bouley,[11] an eminent French professor of veterinary medicine at l'École d'Alfort, described a syndrome of intermittent claudication in a six-year-old mare with occlusion of the femoral arteries. This syndrome was further studied by Goubaux,[12] chief of the Anatomy Section at the same veterinarian school. Goubaux[12] found occlusions in the abdominal aorta and/or its branches, in a series of 11 horses and mares suffering from intermittent claudication. In 10 of these animals (five male and five female) the lesions were palpated through the rectum; and in all 11 cases, autopsy confirmation was obtained. The vascular occlusions were reported to be due to organized mural thrombi, often multiple. These equine lesions were later attributed to an endarteritis caused by the larva of the nematode sclerostoma equinum,[13] a trichostrongyle, for which anthelmintic therapy is now available.

The work of Bouley[11] and Goubaux[12] attracted the attention of Charcot[14] who reported his first human case of intermittent claudication in 1858. Charcot's patient was a 54-year-old house painter who had an intermittent cramping pain in the calves, due to an aortoiliac dissecting aneurysm caused by a bullet wound. The lesion had resulted in bilateral compromise of the iliac arterial circulation and was confirmed at autopsy. Since then, the term "intermittent claudication" has gained wide acceptance in association with vascular occlusive disease involving the lower extremities.

Recognizing Charcot's work,[14] Dejerine[13,15] later described a second type of intermittent claudication for which he coined the term "intermittent claudication of the spinal cord." This syndrome consisted of spastic paraparesis with Babinski's sign, which developed on walking, forced the patient to stop, and disappeared after rest. There was no pain, and the peripheral pulses were present. Dejerine[13,15] attributed this syndrome to an exercise-induced, relative ischemia of the spinal cord, associated with luetic arteritis affecting its blood supply. His ingenious concept of exercise-induced, relative spinal cord ischemia is supported by Blau and Rushworth's[16] experimental evidence that the exercise of an extremity imposes greater demands on the oxygen uptake and blood supply of the corresponding spinal cord segment. There is also evidence that stimulation of other nerve tissues increases their oxygen consumption.[17,18]

A third syndrome of intermittent claudication, later described by Verbiest,[1-3] is characterized by various combinations of back pain, flaccid weakness, incoordination, paresthesia, numbness, or radicular pain in the lower extremities, brought on by walking, forcing the patient to stop, and relieved by rest. Limitation of straight leg raising is variable; but the ankle jerk is almost always absent. The pedal pulses are usually present. For this syndrome, the term "intermittent claudication of the cauda equina" was suggested by Blau and Logue[4] who had encountered it in rare instances of disc protrusion with myelographic block. In Verbiest's[1-3] cases, however, as in most of the cases reported by other authors,[6-9,19] there was an underlying developmental stenosis of the lumbar spinal canal, often with superimposed spondylosis or disc disease further compressing the nerve roots of the cauda equina and/or their associated blood vessels.

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Table 1: Suggested classification of intermittent claudication

Types of Intermittent Claudication	*Salient Clinical Features*
I. Vascular Type (Charcot), due to compromise of arterial supply to lower extremities.	Cramping pain in the exercised muscle, relieved by rest. No radicular distribution. Pedal pulses usually absent.
II. Neurogenic Types:	
A. Intermittent claudication of spinal cord (Dejerine), presumably ischemic.	Spastic paraparesis with Babinski's sign, developing on walking, relieved by rest. Rare. Pedal pulses present.
B. Intermittent claudication of cauda equina.	Associated clinically with lumbar spinal canal stenosis, less commonly with disc disease. Pedal pulses present.
1. *Postural form,* due to direct compression of cauda equina.	Flaccid radicular deficit and/or pain on walking, prolonged standing, or hyperextension of lumbar spine, relieved by rest and/or by forward bending.
2. *Ischemic form,* due to compression of radicular arteries and/or veins.	Similar to postural form, but brought on by exercise regardless of posture, and relieved by rest alone, not by postural change.

In studying the mechanisms involved, Wilson[6] and Wilson and co-workers[7] concluded that there are two forms of neurogenic intermittent claudication, a "postural form" and a less common "ischemic form." The postural form is attributed to the lordotic posture assumed while walking. This posture causes a shortening and consequent decrease in total inner volume of the already stenotic spinal canal, further reduces the inner volume by infolding the yellow ligaments, and results in compression of the nerve roots of the cauda equina. In such cases, the symptoms are reproduced or aggravated on hyperextension of the spine, and relieved on forward bending which lengthens the spinal canal and unfolds the yellow ligaments. The ischemic form, on the other hand, is noted when the symptoms are brought on by exercise alone regardless of posture, and are relieved by rest alone, not by forward bending. The mechanism of the ischemic form may consist of radicular arterial compression by osteophytes,[6,7] or of stasis anoxia from compression of radicular veins.[19]

Since 1964, the term "intermittent claudication of the cauda equina" has been largely replaced by the term "neurogenic intermittent claudication" used by Evans.[5] The latter term should also include Dejerine's[13,15] intermittent claudication of the spinal cord. Involvement of the spinal cord, however, is unusual because the great anterior radicular artery (of Adamkiewicz) enters the spine most often at one of the left lower thoracic segments,[20] while stenosis and spondylosis of the lumbar spinal canal are more common in the mid and lower lumbar vertebrae. Accordingly, neurogenic intermittent claudication is usually limited to the cauda equina without involvement of the spinal cord. However, intermittent claudication of the spinal cord may still occur in association with atheromatous disease of the aorta.[21]

Significantly, as indicated by Wilson and co-workers,[7] neurogenic intermittent claudication may co-exist with Charcot's[14] vascular intermittent claudication, and both aortography and myelography may be needed for diagnosis. However, the suggested classification in Table 1 may facilitate the clinical differentiation between the two syndromes, and may further pinpoint the subdivisions of neurogenic intermittent claudication.

Brief analysis of cases

In a personal experience with 23 consecutive cases of neurogenic intermittent claudication treated in 1970 through 1975 (Table 2), 16 had the postural form, five had the ischemic form, and two had both forms. The male:female ratio was 20:3. The age distribution was 36 to 76 years, with an average age of 60 years. The syndrome is thus seen more commonly in the older male, as previously indicated.[2,3,7,8]

Among the 23 cases of neurogenic intermittent claudication in this series, 14 were associated with stenosis of the lumbar spinal canal, 2 with disc herniations, and 7 with both entities (Table 2).

Two of the 20 cases of lumbar spinal canal stenosis previously published,[8] were excluded from the present series because they had no neurogenic intermittent claudication. The five additional cases in this series were treated in 1975 for neurogenic intermittent claudication associated with disc disease and/or lumbar spinal canal stenosis.

Treatment consisted of wide laminectomy and partial facetectomy, to decompress the nerve roots and blood vessels of the cauda equina. The operation was performed bilaterally in 18 cases. These included one patient who further required complete facetectomy and bilateral lateral fusion for spondylolisthesis. A unilateral operation was performed in four cases, using Verbiest's[3] technique. These included a patient[8] who had been denied an ipsilateral total hip replacement because of marked weakness and atrophy in the quadriceps and gluteal muscles. But within six months from laminectomy, there was enough return of muscle function to justify the total hip replacement, after which the patient became virtually asymptomatic.

Disc herniations were removed in eight cases, including the two patients who did not have stenosis of the lumbar spinal canal. One patient refused operation because of psychiatric problems,[8] and was treated conservatively, with no significant relief.

Of the 22 cases who were operated on, 16 (73%) returned to their premorbid status, five (22%) adjusted to more limited activities, and one (5%)[8] could not be rehabilitated.

Comment

As shown by Salibi,[8] undue delay in diagnosis and decompressive therapy may result in neurogenic bladder, hydroureter, hydronephrosis, pyelonephritis, azotemia and death. Also, since most patients with neurogenic intermittent claudication have stenosis and spondylosis of the lumbar spinal canal, they may sustain serious neurogenic disability from surgical operations performed while the anesthetized patient's spine is in a hyperlordotic or laterally flexed position.[10] A watchful eye should, therefore, be maintained for early recognition and treatment of neurogenic intermittent claudication.

Table 2: Analysis of 23 consecutive cases of neurogenic intermittent claudication (NIC) treated in 1970 through 1975

Case No	*Age*	*Sex*	*Postural Form of NIC*	*Ischemic Form of NIC*	*LSCS**	*IDH***
1	61	M	+	−	+	−
2	76	M	+	−	+	−
3	51	M	−	+	+	−
4	64	M	+	−	+	−
5	72	M	+	−	+	−
6	69	M	+	+	+	−
7	69	M	+	−	+	−
8	52	F	+	−	+	−
9	46	M	+	+	+	−
10	63	M	+	−	+	−
11	61	M	+	−	−	+
12	59	F	−	+	+	+
13	44	F	+	−	−	+
14	57	M	+	−	+	+
15	55	M	+	−	+	+
16	67	M	+	−	+	+
17	36	M	+	−	+	+
18	72	M	−	+	+	−
19	58	M	+	−	+	−
20	60	M	+	−	+	+
21	59	M	+	−	+	−
22	58	M	−	+	+	−
23	75	M	−	+	+	+

* LSCS = Lumbar spinal canal stenosis
** IDH = Intervertebral disc herniation large enough to indicate discectomy.

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When you're hot, you're hot!

Environmental factors in early season practice

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HEAT STRESS reactions in athletes are not chance phenomena. They are predictable and preventable. In spite of increasing local and national attention to heat problems and their treatment: (1) There have been 46 athletic heat stroke fatalities in the United States in the past 10 years and the number per year is increasing.[1-3] (2) Heat stroke remains the second largest cause of death in American football.[4] (3) Nationwide, heat exhaustion occurs in more than 1,000 athletes per year.[5] (4) Subclinical cases of heat stress undoubtedly account for thousands of athletes' periodic decreased efficiency.

Heat fatalities and heat exhaustion will be prevented if one: (1) realizes that "heat stress" conditions can exist in Wisconsin; (2) understands the body's mechanisms for coping with heat; (3) learns to recognize and treat the accumulation of heat; (4) utilizes acclimatization; and (5) insists on water and salt replacement.

Man's body mechanisms for coping with heat

Man dissipates the heat he generates through radiation, convection, evaporation, and excretion. Radiation is heat loss from the skin to surrounding walls and objects. Convection is heat loss to the surrounding air. Evaporation involves loss of heat through absorption of sweat by surrounding air. Excretion relates to heat loss through urine and feces.

When the environmental temperature is less than skin temperature (less than 26.6 C [80.0 F]), 70% of body heat is lost by radiation, conduction, and convection. Thirty percent of the heat is lost by evaporation. When environmental temperature is greater than skin temperature, body heat must be dissipated by evaporation alone. At this point, the body's ability to sweat, and the air's ability to take on moisture become the life or death factors.[2,5]

There are two female characteristics that separate the sexes thermally. Females have a thicker layer of subcutaneous fat than males. This makes it possible for them to withstand cold better than males. The female also has a greater number of sweat glands per unit area of skin than the male, and is thus able to dissipate heat more rapidly at higher temperatures. Females, therefore, can function comfortably at temperatures ranging from 26.6 C to 32.8 C (80.0 to 91.0 F). Males have a restricted comfort range of 28.0 to 30.5 C (82.0 to 87.0 F). Both sexes, however, suffer from heat stress reactions if there is an imbalance between heat generated and heat lost.

Heat illnesses

The illnesses that are the result of excessive heat accumulation include: heat syncope, heat cramps, heat exhaustion, and heat stroke. These syndromes are part of a continuum and should not be considered as isolated entities.

Heat fainting or *syncope* is due to blood pooling in the lower body. This occurs after sitting or standing in a hot environment. The athlete quickly recovers after horizontal positioning with the legs elevated.

Heat cramps are due to rapid salt loss. The athlete complains of repeated leg and abdominal cramps. These cramps should not be confused with the isolated cramp of muscle overuse. This syndrome indicates inadequate salt intake. Symptoms clear rapidly and the athlete can resume activity following adequate salt replacement.

Heat exhaustion is caused by either salt and/or water deficiency. The salt depletion type is caused by excessive salt loss in sweat. This type of heat exhaustion is seen during the first few days of practice when salt content in sweat is high due to lack of acclimatization. The symptoms are increasing weakness, fatigue, headache, nausea, vomiting, and muscle cramps. The patient will have hemoconcentration demonstrated by an increasing blood urea nitrogen and hematocrit. This athlete should be hospitalized and treated by sodium chloride replacement over one to three days. He may usually return to activity in two to five days.

The water depletion type is the result of inadequate fluid replacement. This type of exhaustion develops over several days. It is characterized by a decreasing body weight and a decreasing urine output. The symptoms are the same as in the salt depletion type with the addition of increasing thirst. Signs of dehydration, and cerebral dysfunction may occur. This is often an elusive diagnosis since symptoms are not distressing and often not reported. One can suspect water depletion only if weights of the athletes are observed closely. Treatment is rehydration over two to three days. The need for hospitalization is determined by the severity of the symptoms.

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Heat stroke or heat hyperpyrexia is the result of a thermal regulatory failure. Rectal temperatures are greater than 40.5 C (105.0 F). There is severe cerebral dysfunction, and dry skin. Prestroke symptoms are the same as those given for heat exhaustion. Cerebration may become so disturbed that one is forced to make the diagnosis by the physical findings alone. In addition to the increased temperature and hot-dry skin, there may be ecchymosis, vomiting, and convulsions.

Heat stroke is a medical emergency. Minutes are precious in preventing death. The mortality and morbidity correspond to the length of time the patient has an elevated temperature. The athlete's temperature must be lowered to 39.0 C (102.0 F) within the first hour. The cooling must start with the coaches and trainers. They should immediately strip, ice, and fan the victim while moving him to a hospital. After hospitalization, the patient is placed in an ice-water bath until the rectal temperature decreases to 39.0 C (102.0 F). The patient is then moved to a room equipped with cooling blankets and fans. Thirty to 50 mg of chlorpromazine (Thorazine®) is given intravenously every 30 minutes to create a hibernation effect. This medication should allow rapid temperature lowering without marked muscle activity. The medication is discontinued when temperatures have been lowered to 39.0 C (102.0 F). If treatment is immediate and aggressive, the patient should have a complete recovery and eventually return to athletics.[4] Physicians treating a case of heat stroke should review the current medical literature on the neurological, liver, renal, and hematological complications.

Prevention of heat stress reactions

Experts[1-4] feel that the following measures will eliminate a majority of heat stress reactions:

(A) *History and physical examination.* Every athlete should have a complete medical history taken and a preseason physical examination. Emphasis should be placed on previous heat illness. High risk athletes should be identified. Those at risk include: those unaccustomed to working in heat, the overweight, the over-eager individual, and the ill athlete with a history of vomiting, diarrhea or fever.

(B) *Physical conditioning.* One must determine the amount of work done in heat during the previous month. The athlete who has worked in an air-conditioned office all summer or has done his workouts in the cool of the evening is certainly not prepared to practice in heat. One should also ascertain the patients general physical conditioning. A method used at the University of Wisconsin is the 12-minute run. This is staged the first morning of practice. Relatively well conditioned linemen can cover one-and-three-fourths miles in that period[6] (Table 1).

(C) *Temperature and humidity measurements.* One must measure the temperature and humidity on the practice field. These values should be obtained before and during practice. The military method of determining the heat index requires a wet bulb-globe thermometer. This three-thermometer device does not seem to be practical even for college athletics due to its expense and required calculations. An inexpensive, simple and effective device is the wet bulb-black globe thermometer.* This device consists of two thermometers. The bulb of one is mechanically kept wet. The heat index is easily determined from the scale printed on the device. A safe level of practice activity can be determined after one knows the heat index.

It is best to measure one's own field temperatures, but if this is not possible, hourly dry and wet bulb readings can be obtained from local weather stations. There is a class I weather station at all commercial airports. Safe levels of activity for varying wet bulb readings have been determined[2,3] (Table 2).

Levels of heat and humidity that adversely affect the athlete are not peculiar to the South. On the average Wisconsin has eight days in late August and three days in September with temperatures greater than 29.4 C (85.0 F) and wet-bulb temperatures greater than 15.5 C (60.0 F).[7]

(D) *Clothing.* Long-sleeved, close-knit jerseys and full T-shirts decrease evaporation and should not be used in hot weather. The use of wet suits should be condemned. The player who is forced to exercise in a wet suit suffers water loss, not fat depletion. The only thing the athlete is burning is his brain, not his calories.

(E) *Acclimatization of the athlete.* Acclimatization is predictable body adaptation to a constant environmental stress placed upon it. The stress referred to here is heat. The adaptations of an acclimatized athlete include increased sweat production at a lower temperature, increased sweat output per gland, and decreased salt content in the sweat. There is also a greater blood flow through the skin with less work on the heart.

Acclimatization can be accomplished through four to six weeks of regular, daily exercise in heat. Upon completion of this exercise

Indeed when your athlete's hot, he's hot,
And if missed, this could hurt him a lot.
If you condition, check weight, give fluid on the spot,
A heat reaction won't be what your athlete's got.

*Physio-Dyne indicator, Commercial Products Division Environmental Tectonics, Newton, Pa 18940.

program one may safely begin three to four hours of work in heat in full equipment. A minimum of three to four hours work per day in heat for four to seven days is necessary.

(F) *Recording weights pre- and postpractice.* If an athlete loses 3% of his body weight, his activities should be curtailed. The athlete that loses five pounds or more should be observed closely. One that loses greater than 10 pounds should be withheld from further activity. Failure to gain weight overnight is a definite sign of dehydration.

(G) *Rest intervals.* During times of acclimatization, a 10 minute rest should be given every 30 minutes. This should be done in a cool, shaded area with removal of helmets and jerseys.

(H) *Fluid replacement.* Ten oz of saline solution is given during each rest period.[6] Many expensive salt solutions are available. An inexpensive and effective solution can be made from ice, coolade, and salt. Cold solutions empty more rapidly from the stomach. Little, if any, sugar should be added to the solution since this will retard gastric emptying.[8]

One to four teaspoons of salt should be added to each gallon of water for the first three days of acclimatization. The salt is then decreased to two teaspoons per gallon until cooler weather is encountered. One five grain salt tablet is given per pound of weight loss over 5 lb.[9] Potassium loss in sweat and urine is adequately replaced by a normal diet unless the athlete is suffering from diarrhea or vomiting.[10]

There is no scientific evidence to support the opinion that withholding water makes an athlete tougher. Water losses must be replaced hour by hour or performance will decrease.[9] The athlete gets into trouble by too little—not too much —water.

(I) *Education.* The team physician, alone, cannot prevent heat stress reactions. Evaluation and treatment are dependent upon the athlete reporting his symptoms and the coach and trainer recognizing a heat reaction. The athlete, coach, and trainer must be taught the signs and symptoms of excessive heat accumulation. The responsibility of educating this group rests with the team physician. An annual preseason discussion of this problem should be held.

Table 1—12 Minute Run

	*Athletes Condition—Distance Covered**		
Position	Poor	Fair	Good
Linemen	<1 Mi	1-1.5 Mi	≥1.75 Mi
Backs and Ends	<1.25 Mi	1.25-1.75 Mi	≥2.0 Mi

*Subtract one-quarter mile for underclass-highschool athletes

Table 2

Wet Bulb Temperature	*Precautions*
Under 15.5 C (60.0 F)	None necessary
16.1 C - 18.3 C (61.0 F - 65.0 F)	Alert observation of all athletes who have heavy weight loss
18.8 C - 21.1 C (66.0 F - 70.0 F)	Insist that salt and water be given on the field
21.6 C - 23.9 C (71.0 F - 75.0 F)	In addition to above precautions, provide a rest period every 30 minutes
Over 23.9 C (75.0 F)	Practice postponed or conducted in shorts

Summary

Can heat stroke be eliminated as a cause of death in American football? The answer is unequivocally yes. A preventive program must include: (1) realizing that "heat stress" conditions can exist in Wisconsin, (2) assessing preseason conditioning, (3) taking a thorough history and providing a physical examination, (4) recording weights before and after practice to determine those athletes at risk, (5) utilizing the "heat index" to set safe levels of activity, (6) insisting on adequate salt and water replacement, (7) acclimatizing the athlete to working in hot conditions, and (8) educating the athlete, coach, and trainer about the signs and symptoms of heat reactions.

EDITOR'S NOTE: The State Medical Society's Communications Department will be distributing reprints of this article to all Wisconsin high school coaches.

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Vesicular eruption in newborns secondary to maternal propylthiouracil therapy: Report of two cases

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• We describe two neonates with generalized vesicular lesions whose mothers received propylthiouracil (PTU) during pregnancy for treatment of hyperthyroidism. Bacterial, viral, and toxic etiologies for the eruptions were not proven. We postulate that transplacental transfer of PTU may produce an allergic skin eruption and result in vesicular lesions in the newborn.

Figure 1—Vesicular lesions on a slightly erythematous base. Case 1 at three days of age.

THE THIAMIDE DRUGS, propylthiouracil (PTU) and methimazole (MET) have been widely used for the treatment of hyperthyroidism for over 25 years.[1] Toxic skin reactions occur in 3% to 5% of adults[2] and up to 18% of children.[3] Although antithyroid drugs are extensively used for the treatment of hyperthyroidism in pregnancy[4] and readily cross the placenta,[5] allergic reactions in the neonate have not been reported. We present two probable cases.

Case reports

Case 1. A male weighing 3.05 kg was born at 40 weeks gestation by an uncomplicated vaginal delivery. The mother had Graves' disease, which was easily controlled with antithyroid drugs, and was well during pregnancy. She was receiving 50 mg of PTU three times daily and triiodothyronine (Cytomel®) 25 μg twice daily at delivery. The Apgar at 1 minute was 6 and at 5 minutes, 8. Initial physical examination revealed no abnormalities other than vesicles over the thorax, posterior neck, left ear, forehead, and abdomen (Fig 1).

At age two days, the infant ceased eating, began to vomit, and was lethargic. The temperature was 37.7 C; the pulse was 120 beats per minute. There were no new vesicular lesions and the physical examination remained normal.

At age three days, the patient developed jaundice. The peripheral white blood count was 16,600 per cu mm, with 51% segmented neutrophils, 12% nonsegmented neutrophils, 26% lymphocytes, 8% monocytes, and 3% eosinophils. The hematocrit was 64.8% and the hemoglobin 22.3 gm per 100 ml. The direct bilirubin was 0.5 and the total bilirubin 10.0 mg per 100 ml. The infant's and mother's blood types were A, Rh positive and O, Rh positive, respectively. Serum glucose was 67 mg per 100 ml; serum sodium was 131; potassium, 4.6; chloride, 85; and bicarbonate, 15 mEq per liter; calcium was 8.0 mg per 100 ml. The thyroxine determined in cord blood was 6.3 and at age three days was 12.0 μg per 100 ml (normal adult range, 3.8-8.5 μg per 100 ml).

Examination of the vesicular fluid revealed a moderate number of segmented neutrophils. However, five cultures of the vesicular fluid were negative for pathogenic organisms, and one culture was negative for fungi. Cultures of the nose, throat, urine, and stool were also repeatedly negative for pathogenic bacteria. A blood culture was sterile at age two days. A blood culture obtained at age three days grew Escherichia coli. Two subsequent blood cultures were sterile. Cultures of vesicular fluid in kidney tissue, continuous line tissue, and diploid tissue were negative for Herpesvirus hominis.

Because sepsis was considered a diagnostic possibility, the patient was placed in an Isolette. Methicillin and kanamycin therapy was instituted at age two days. Intravenous fluids were administered by an umbilical catheter and fresh frozen plasma (10 ml per kg) was given on days four to seven. By age five days, the infant was alert and began to take oral nourishment. New crops of vesicles appeared on the nape of the neck on day 12. Cultures were again sterile. Antibiotics were discontinued on day eight.

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The patient remained afebrile throughout his hospital course, and hemolysis and anemia did not develop. The vesicular lesions cleared, and the patient was discharged on day 25, appearing normal.

Case 2. A male weighing 3.03 kg was born at 40 weeks gestation by vaginal delivery. Eight hours prior to delivery the membranes spontaneously ruptured, but the delivery was otherwise uneventful. The mother had hyperthyroidism due to Graves' disease and was treated during pregnancy with decreasing doses of PTU. She was well during pregnancy and at delivery was receiving 100 mg PTU three times daily and 180 mg desiccated thyroid daily. Immediate Apgar score was six and at five minutes was eight. Initial examination of the infant was normal except for several vesicles on the forehead, right thigh, and back.

At age two days, the infant became lethargic and developed jaundice. The physical examination revealed a temperature of 37.6 C and a pulse of 100 beats per minute. More vesicles were noted. There was no hepatosplenomegaly or thyroid enlargement.

The hemoglobin was 20.6 gm per 100 ml; hematocrit, 62.9%; and red blood count, 5.16 x 10^6 per cu mm; 20 nucleated red blood cells per 100 white blood cells were seen; and the reticulocyte count was 9.2%. The peripheral white blood count was 23,200 per cu mm with 62% segmented neutrophils, 4% nonsegmented neutrophils, 25% lymphocytes, 4% monocytes, and 5% eosinophils. The platelet count was 60,000 per cu mm. The direct bilirubin was 1 and the indirect bilirubin 13 mg per 100 ml. Direct and indirect Coombs' tests were negative. The blood type of the infant and the mother was B, Rh positive. A glucose-6 phosphate dehydrogenase deficiency was not demonstrated.

The urinalysis, lumbar puncture, chest x-ray film, serum glucose, calcium, sodium and potassium were normal. The serum thyroxine determined on cord blood was 8.2 and at age four days was 8.0 μg per 100 ml (normal adult range, 3.8-8.5 μg per 100 ml).

Cultures of the nose, throat, blood, spinal fluid, urine, and stool were repeatedly negative for pathologic organisms. The vesicles were cultured on five occasions and were also sterile. Attempts to isolate the Herpesvirus hominis by culture in kidney tissue, continuous line tissue, diploid tissue, and mice were unsuccessful.

The infant was placed in an Isolette and treated by phototherapy. Intravenous infusions of penicillin G and intramuscular injections of kanamycin were administered. Ointment containing polymyxin B, bacitracin, and neomycin (Neosporin®) was applied to broken vesicles. The infant remained afebrile, anemia did not develop, and the jaundice cleared. At age four days the infant began to take nourishment, and intravenous fluid therapy was discontinued. He continued to improve and was discharged at age ten days. At the time the peripheral white blood count had fallen to 7,400 per cu mm with 16% neutrophils, 78% lymphocytes, 4% monocytes and 2% eosinophils. The hematocrit was 54.2% and the hemoglobin, 18.2 gm per 100 ml.

The baby was well when examined again at age 17 days. He weighed 3.4 kg, and the vesicular lesions were healed.

Discussion

The differential diagnosis of the common vesicular eruptions in the immediate neonatal period includes toxic erythema, rash associated with phototherapy, viral eruptions, and skin lesions associated with sepsis. Although lethargy suggested sepsis in both infants, one patient had persistently negative blood cultures and only one blood culture was positive for pathogenic bacteria in the second. The rashes were morphologically not typical for a septic rash; the vesicular fluids were not purulent, did not contain bacteria on histological examination, and were repeatedly sterile when cultured for bacteria and Herpesvirus hominis. Both infants were afebrile, temperature instability and manifestations of toxicity typical of sepsis were not present. In addition, there was no premature rupture of the membranes or evidence of maternal sepsis. The vesicles were present at birth and prior to institution of phototherapy. Thus, although not conclusive, there is no evidence for a toxic, viral, or bacterial etiology for the vesicles.

Treatment with PTU rarely produces hepatitis.[6] Although the two infants were jaundiced, the indirect hyperbilirubinemia, the lack of cholestasis, and the rapid clearing of the jaundice mitigates against a PTU-produced hepatitis. The jaundice probably represents physiologic jaundice of the newborn.

The allergic manifestations of thiamide drugs include skin reactions, granulocytopenia, agranullocytosis, thrombocytopenia, fever, and a lupus-like syndrome.[2,3] Skin eruptions occur in 3% to 5% of adults treated with antithyroid drugs. Most of these are mild and usually manifested by a pruritic, maculopapular eruption. Urticarial lesions are rare.

The toxic manifestations of antithyroid drugs are more frequent in children. One study[3] indicates a 45% incidence of toxicity in which 18 of the 38 hyperthyroid children developed a rash or urticaria. Hung and associates[7] also found 3 cases of urticaria (13%) among 23 hyperthyroid children treated with antithyroid drugs.

The skin of children and especially infants differs from that of the adult.[8] The inflammatory response is accompanied by the accumulation of relatively greater amounts of fluid. For example, the bullous and vesicular eruptions common in infants with congenital syphilis and mast cell disease are never seen in adults with these disorders. Thus, the vesicular lesions in our two infants may represent this phenomenon.

Antithyroid drugs are widely used to treat hyperthyroid mothers during pregnancy.[4] Because the drugs readily cross the placenta[5] and block fetal thyroid hormone synthesis, fetal goiter and/or fetal hypothyroidism was a major problem.[9] However, reduction of the dose has ameliorated these complications without compromising the well being of the mother.[10]

Although congenital scalp defects may be related to the maternal use of antithyroid drugs,[11] we found no reports of allergic reactions in the newborn secondary to antithyroid or other drugs ingested by the mother. We postulate that the vesicular eruptions present at birth in the two neonates were due to transplacental sensitization to PTU. Because toxic effects[12] and neonatal goiter[9] may be dose related, we currently recommend treating pregnant women with the lowest possible dose of antithyroid drugs.[11]

However, we caution that transplacental passage of the drugs may rarely produce an allergic reaction in the infant.

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COMMENTS ON TREATMENT

Aerosol beclomethasone: an important new steroid treatment of chronic, severe asthma

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AEROSOL BECLOMETHASONE, a potent topical steroid, has been used in Europe for the treatment of asthma for more than five years; it now is available in the United States. The drug is effective in the maintenance treatment of chronic asthma, and may largely replace oral corticosteroids for this purpose because it carries little or no systemic glucocorticoid effects. In patients who have normal functioning adrenal-pituitary-hypothalamic axis, suppression rarely occurs with doses less than 1200 μg of aerosol per day, although suppression begins to occur with higher doses.

Beclomethasone (Vanceril®) is packaged as a micronized powder propelled by freons. Each metered dose delivers about 50 μg. The usual therapeutic range is 400 μg to 800 μg per day in four divided doses; some patients may benefit from higher dosage levels, although there rarely is cause to raise the dose above 2000 μg per day. The drug is safe for children and effective once techniques of administration are mastered.

Currently, the indication for the drug's use is severe, chronic asthma, perennial or seasonal, not controlled by optimum doses of theophylline and sympathomimetic bronchodilators. Beclomethasone should not supplant bronchodilator therapy but be added to it. In general, however, it may supplant long-term maintenance treatment with prednisone or other oral steroids. We suggest an initial dose of 400 μg (2 puffs, four times a day) per day for persons using less than 20 mg of prednisone every other day and 800 μg (4 puffs, four times a day) per day for persons using more than 20 mg of prednisone every other day. Oral corticosteroids should be withdrawn slowly over 8 to 12 weeks after beclomethasone therapy is initiated. Slow withdrawal will generally avoid both sudden changes in the asthma and steroid withdrawal symptoms. The patient should be seen at least once a month while

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the oral steroid is being withdrawn. Office spirometry (FEV_1 and FVC) is helpful in following the patient's progress and in detecting declining pulmonary functions. Elderly patients, patients using oral steroids for more than five years, or those on high doses of oral steroids must be followed with particular care; physicians with particular interest in asthma may be able to help follow these patients during steroid withdrawal.

Thorough patient education in the use of the device is mandatory and supervised practice with it is useful. We instruct our patients as follows: (1) shake the canister vigorously before using, (2) tip back the head and insert the mouth piece into the mouth, (3) depress the plunger during slow, deep inspiration, (4) hold the breath and then exhale through the nose, and finally (5), gargle thoroughly with water, since up to 90% of the dose is deposited in the oral pharynx and will be swallowed.

Patients should also be instructed in the pitfalls of aerosol treatment. They need to know that the aerosol should not be used to treat acute bronchospasm, but rather should be used according to a set, regular schedule. A few days of supplemental oral corticosteroids may be required for severe exacerbations of asthma, particularly those provoked by upper respiratory viral infections. Patients without adrenal reserve may die of an asthma attack if not promptly treated with prednisone or similar steroid. Oral or parenteral steroids may also be required with surgery, severe infection, or other "stress," since many months may be required to recover hypothalamic - pituitary - adrenal function. We encourage our patients to carry a card in their wallet or purse alerting emergency personnel to their history of chronic oral corticosteroid use. Steroid withdrawal symptoms, especially muscle aching and stiffness, are common during the transition period from oral to aerosol administration. Other allergic diseases such as eczema and nasal polyps may flare. The chief complications have been mild hoarseness (but severe enough to prevent continuing the treatment in only about one percent of patients) and oral thrush.

We have followed 64 patients using beclomethasone for an average time of five months. Forty-six were dependent upon oral steroids for control of their asthma; 32 of these 46 patients have been able to completely eliminate the oral steroids. The remaining 14 have been able to reduce the prednisone by about 50 percent. The group as a whole has done well, with an average increase in the FEV_1 of 10 percent. Three patients have been unable to use the aerosol delivery device properly and have continued on oral steroids. Elderly patients, patients using oral steroids for more than five years, and patients using more than 20 mg every other day of prednisone had the greatest difficulty withdrawing from prednisone. Successful prednisone withdrawal has been complicated by return of rhinitis or nasal polyps (19 of 46). These nasal symptoms are not easily managed by antihistamines-decongestants, and often require intra-nasal beclomethasone or dexamethasone treatment. On occasion we have initiated short courses of oral steroids to cope with severe nasal symptoms; two patients opted to return to oral steroids because of nasal obstruction. A few patients (7 of 46) complained of transient myalgias, arthralgias or postural dizziness during oral steroid withdrawal, but no patient suffered from acute hypoadrenalism. Oral thrush has been seen in only two patients; both were treated with topical nystatin without discontinuation of the beclomethasone. We find that we must remind some patients to continue the beclomethasone in a regular fashion, although some have been able to reduce the dose to 200 or 300 μg per day. Exacerbations of asthma with upper respiratory infections required short courses of oral prednisone for control in 15 of the 64 patients.

In summary, aerosol beclomethasone is an important addition to the armamentarium against bronchial asthma. About 70 percent of steroid dependent patients will be able to eliminate the oral steroids. Several precautions must be kept in mind when aerosol beclomethasone is used to treat asthma: (1) Patients who are elderly or using steroids at high dosage for prolonged periods may not be able to withdraw completely from the oral steroids; management of these patients is often complicated by very slow recovery of hypophyseal-pituitary-adrenal function. (2) Patients successfully withdrawn from the oral steroids may have substantial difficulty with exacerbation of dermatitis, rhinitis and/or nasal polyps; courses of oral or intranasal topical steroids may be required. (3) Oral thrush and hoarseness are common complications. In about 1% of the patients those complications are severe enough to require stopping the treatment. (4) Exacerbation of asthma will require a short course of supplemental oral corticosteroids. But beclomethasone is safe and effective therapy for severe, chronic asthma when accompanied by careful physician observation and clear patient understanding. ■

Post dates pregnancies

EDITOR'S NOTE: The following article attempts to give some facts and recommendations about post dates pregnancy which, hopefully, will serve as guidelines to physicians delivering primary obstetrical care. The material presented is only part of a more comprehensive report to be published at a later time.

FEW OBSTETRICAL problems have generated more controversy than prolonged pregnancy. A recent article by Vorherr[1] illustrates the diametrically opposed opinions and observations regarding post dates pregnancies.

Basically, two schools of thought have emerged regarding post dates pregnancies. Some authors have come to regard post dates pregnancy as a significant risk to the fetus and advocate termination of pregnancy at 42 weeks gestation to minimize those risks. Others have disputed the belief that post dates, by itself, represents a significant risk to the fetus. These authors expressed the belief that the complications of induced labor and forced delivery, solely on the basis of prolonged pregnancy, outweighed any advantages.

In an effort to resolve some of the issues, 104 pregnant patients with gestational ages of more than 42 weeks were entered into a special protocol at the University of Wisconsin Perinatal Center at Madison General Hospital.

The protocol called for induction of labor if the cervix was favorable, otherwise, weekly Oxytocin Challenge Tests (OCT) and urinary estriols three times per week were done until the patient went into labor. During labor, all fetuses were monitored continuously, employing a scalp electrode and a fetal monitor. Fetal scalp blood sampling was obtained when indicated.

The results of the study were as follows:

1. Approximately 8% of the patients had a positive OCT.
2. 20% of the patients underwent cesarean section for either fetal distress or nonprogressive labor.
3. 38% of the patients demonstrated fetal distress during labor.
4. 15% of the neonates required resuscitation.
5. 21% of the neonates showed evidence of dysmaturity.
6. 26% of the patients had meconium stained amniotic fluid and 18% of the neonates had meconium aspiration.

Based on these results, the following conclusions and recommendations seem justified.

1. Pregnancies carried beyond 42 weeks gestation should be terminated by induction only if the cervix is favorable.
2. In the presence of an unfavorable cervix, it is safe to allow the pregnancy to continue if placental evaluation is systematically carried out with weekly Oxytocin Challenge Tests and urinary estriols at least three times per week.
3. Perinatal morbidity is high in post dates pregnancy; therefore, even in the presence of normal placental function tests, post dates babies must be carefully monitored during labor. Competent personnel to institute appropriate neonatal resuscitation should be present at each post dates delivery.
4. The term postmaturity should be used only when the syndrome of dysmaturity is seen in post dates babies.

As a result of the increased perinatal morbidity and the recommendations made above, it would seem appropriate that post dates patients ought to be delivered at a regional perinatal center if we are to minimize the risks to the post dates newborn.

Reprint requests to: Wisconsin Perinatal Center, Southcentral Region, 202 South Park St, Madison, Wis 53715.
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Vascular surgery update—1976

Jonathan B Towne, MD, Milwaukee, Wisconsin

NINETEEN SEVENTY-SIX is the Silver Anniversary of the modern era of vascular surgery, which began in 1951 when DuBost of France resected an abdominal aortic aneurysm and replaced it with an aortic homograft. The introduction of vascular prosthetic grafts by Voorhees and Blakemore the following year initiated a period of rapid development of vascular surgical techniques. In the last five years there has been a rapid increase in the development of noninvasive techniques for the evaluation of blood flow. One of the most promising is the oculoplethysmograph (OPG) which has been developed by Kartchner[1] and his group to noninvasively evaluate cerebral blood flow. The OPG measures and compares the arterial pulse curve in each eye simultaneously by plotting the change in the volume of the globe with each pulsation. Fluid-filled eye cups, which are connected to a transducer, are applied to each eye. As the globe expands with each arterial pulsation, it withdraws itself from the eye cup creating a negative pressure. The pressure tracing for each eye is plotted simultaneously with a differential curve which represents twice the difference between the eyes.

A densitometer applied to one ear measures the arterial flow curve in the external carotid artery. This serves as the standard for timing the flow to the eyes. Since the ophthalmic artery is the first branch of the internal carotid artery and is normally the major blood supply to

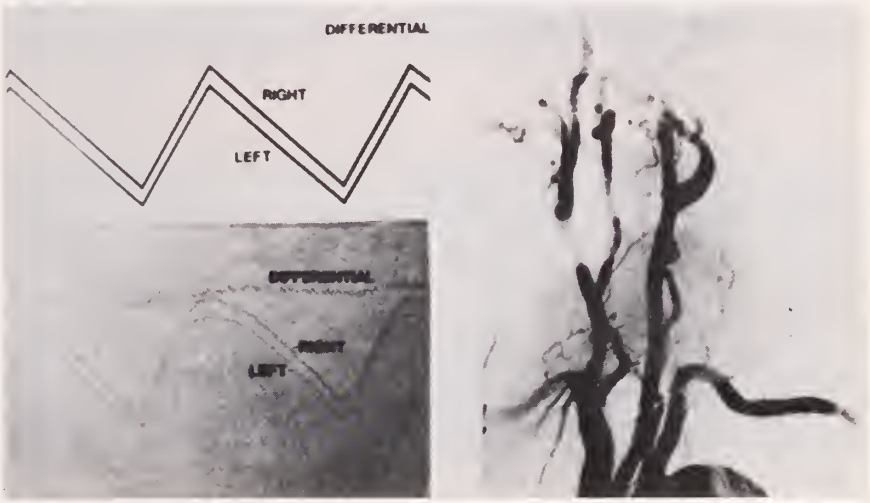

Figure 1—Normal OPG tracing. Note that the different tracing is flat.

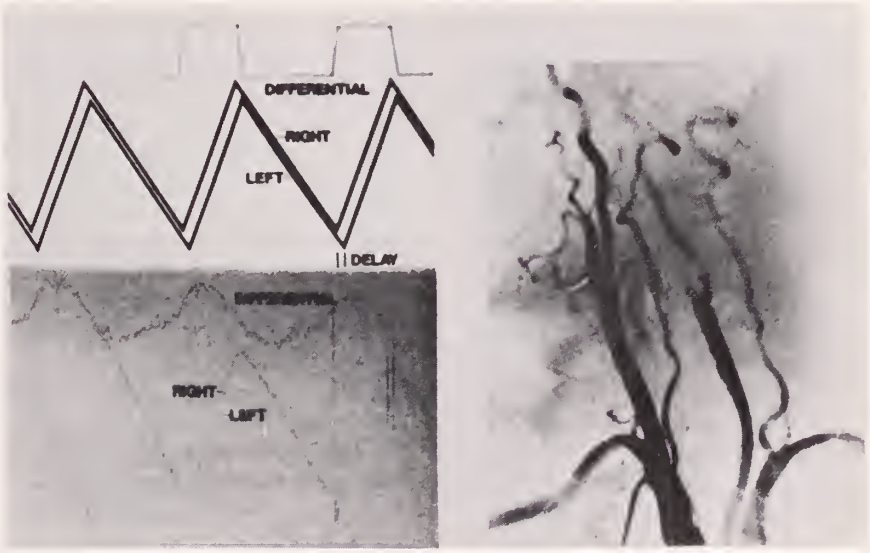

Figure 2—Marked reduction in flow in left internal carotid artery. Note that the differential has a positive deflection.

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Figure 3—Normal phonoangiogram.

Figure 4—Moderate bruit heard over carotid bifurcation. Note how the first heart sound extends into systole.

Figure 5—Loud bruit associated with marked stenosis of the internal carotid artery. The bruit extends into diastole.

the globe and periorbital tissues, internal carotid artery obstruction will result in a delay in the upsweep of the arterial pulse curve on the affected side. The onset of arterial inflow is the most important finding in evaluating these tracings. The slope of the inflow as well as its peak are helpful also in the interpretation. The differential curve is obtained electronically by subtracting the area under the curve of the right eye from the area under the left eye and doubling it. A flat differential indicates a normal tracing (Fig 1). Therefore, if the differential has a negative deflection, there is flow reduction in the right internal carotid artery. If there is a positive deflection, there is flow reduction in the left internal carotid (Fig 2). The differential is sensitive enough to detect small flow reductions that are not visually obvious by examining the tracings of both eyes.

The phonoangiograph (PA) is used in conjunction with the OPG. This machine gives a visual tracing of the auditory components of blood flow. Bruits can be detected and are displayed on an oscilloscope screen from which Polaroid pictures are made for permanent records. Figure 3 demonstrates a normal tracing showing the first and second heart sounds. Figure 4 demonstrates a soft bruit. Notice that the acoustical tracing extends well into systole beyond the normal first heart sound. Figure 5 depicts a harsh bruit. The tracing extends throughout systole.

In 5,000 studies performed over five years Kartchner and McRae[1] found the OPG-PA was 90% accurate when compared to arteriography, 95% accurate when compared to intraoperative flow studies obtained in those patients coming to surgery. There were 6% false negatives and 4% false positives. Most of the false negatives were in patients with bilateral lesions of the internal carotid artery. This group of patients is the most difficult to evaluate because the flow reductions are symmetrical.

The OPG and PA are useful clinical tools for the evaluation of patients for arteriography who have asymptomatic carotid bruits or atypical nonhemispheric symptoms of cerebrovascular insufficiency. These tests also provide a means of serially following patients with lesions not significant enough for endarterectomy or who are postoperative carotid endarterectomy. The greatest asset of the OPG-PA is the added precision afforded physicians in selecting patients for arteriography, thereby decreasing the number of negative studies. Since this test depends upon blood flow, lesions such as ulcerated plaques which may not be hemodynamically significant would not be detected.

Another current topic in peripheral vascular surgery is the revascularization of the profunda femoris artery. The profunda femoris artery provides the principal collateral flow to the lower extremity when the superficial femoral artery is occluded. The profunda arises from the lateral aspect of the common femoral artery and passes among the adductor muscles of the thigh supplying, via its perforating branches, all thigh muscles. Branches of the perforating arteries anastomose with muscular branches of the popliteal and medial and lateral geniculate arteries.[2] There usually are three perforating branches. These pass backward close to the linea aspera and give

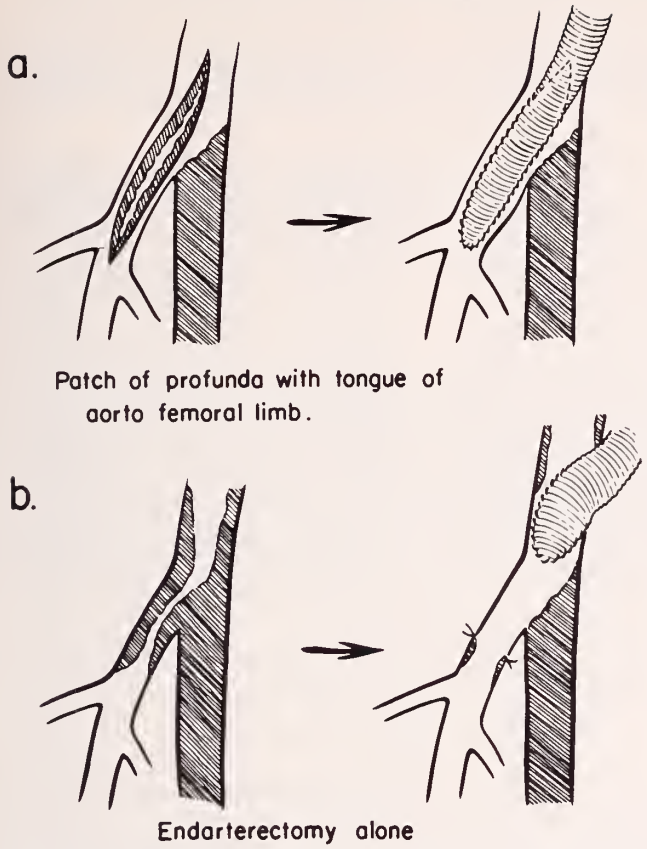

Figure 6—Technics for repair of the profunda femoris artery. (a) Extension of a tongue of the limb of an aortofemoral graft onto the proximal portion of the deep femoral artery. (b) Aortofemoral bypass with endarterectomy of the orifice and proximal 2 cm of the profunda. The distal intima is tacked down to prevent dissection.

[Figures 6 and 7 appeared in Bernhord VM, Militello JM, and Geringer AM: Repair of the profunda femoris ortery. Am J Surg 127:676-679 (June) 1974.]

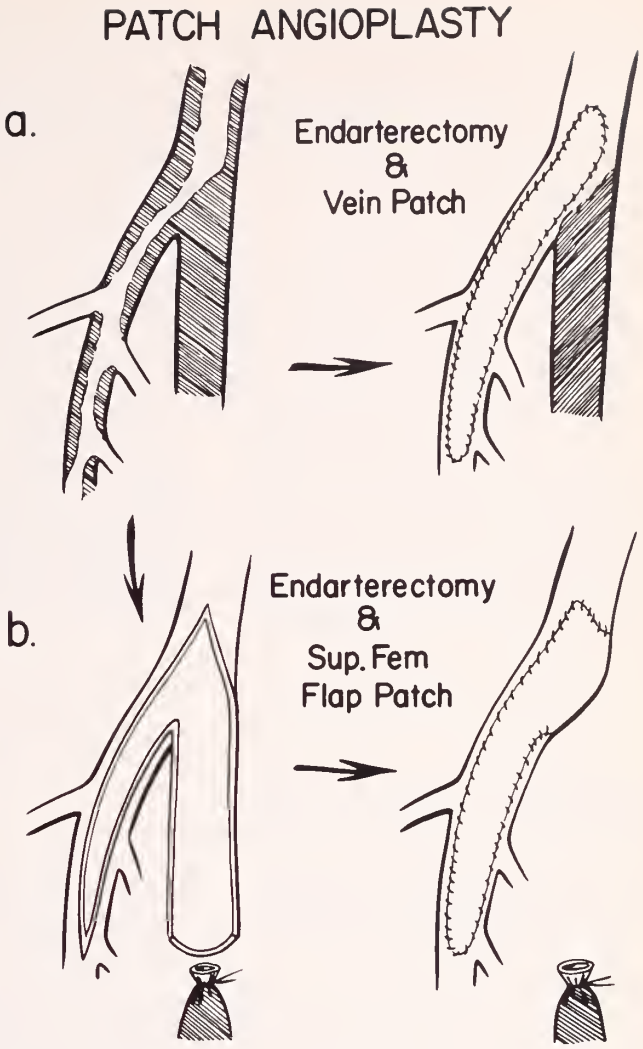

Figure 7—Technics for repair of the profunda femoris artery. (a) Endarterectomy and vein patch angioplasty. (b) Endarterectomy and angioplasty with flap patch employing endarterectomized superficial femoral artery.

off branches joining each other both in front and behind the linea aspera. The arteria collateralis magna, a large muscular branch from the popliteal to the region of the vastus medialis, is usually large in the presence of superficial femoral obstruction, anastomosing with the terminal branch of the profunda.

Distribution of disease in the profunda femoris is classified into three types.[3] Type I is proximal, affecting the segment from the orifice to the first major penetrating artery, and occurs in 74% of the cases. Type II is distal, affecting the segment from the first perforating artery to the termination of the artery and occurs in 12% of the cases. Type III represents diffuse disease and is present in 14%.

Oblique x-ray films are necessary to adequately visualize the origin of the profunda, which is usually located on the lateral or posterior lateral portion of the common femoral. Beales et al[4] found that in a series of 82 patients with occlusive disease at the origin of the profunda, only 28.4% of the profunda stenoses were seen on the standard frontal view. The remaining lesions were only seen adequately on the oblique view. It is, therefore, necessary to obtain both frontal and oblique views to adequately study the profunda femoris artery.

There are two principal uses for profundaplasty. The first is as an adjunct to an inflow procedure where an attempt to increase runoff is necessary, usually in conjunction with aorto-femoral or femoral-femoral bypasses. The other is as an alternative to distal bypass in patients with femoral-popliteal occlusive disease.

To perform a profundaplasty an arteriotomy is made in the common femoral artery and extended into the profunda femoris artery to the distal extent of the disease. Often all that is required is the removal of a proximal plug of atheromatous

material at the orifice of the profunda with tacking of the distal intima and closure with a patch (Fig 6). Not infrequently, a long 10 to 15 cm arteriotomy in the profunda is required to get beyond the diseased segment (Fig 7). All branches of the profunda are endarterectomized if necessary. An endarterectomy of the profunda is done if the plaque is irregular and/or ulcerated. If the profunda is just narrowed by a thick smooth posterior plaque with no impingement on the branches, an endarterectomy is not done and the artery is patched open. Occasionally the disease extends throughout the profunda femoris. In this instance the arteriotomy will extend to the third perforatory branch and terminated. Saphenous vein is the first choice for patching material. Knitted Dacron and bovine grafts have also been used. When the superficial femoral artery is occluded, it can be endarterectomized and used as a patch graft.

The reported results of profundaplasty have been excellent. Martin et al[3] reported a limb salvage rate of 82% in patients in whom profundaplasty alone was done. The salvage rate was 89% in 173 limbs where profundaplasty was done in conjunction with an inflow procedure. Bernhard et al[5] reported improvement in 67% of 87 profundaplasties done for limb salvage. Eight patients had amputation despite a patent reconstruction. He reported improvement in 25 of 26 extremities which had profundaplasty for treatment of claudication.

These data demonstrate the value of profundaplasty in the revascularization of the ischemic extremity.

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ABSTRACT WISCONSIN AUTHORS

Preoperative risk factors and aorta-coronary bypass graft patency

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J Thorac Cardiovasc Surg 72:778-783 (Nov) 1976

We have studied 636 patients who before and after aortocoronary vein bypass surgery had coronary arteriography and the following preoperative determinations: serum cholesterol, serum triglyceride, age, height, weight, systolic pressure, diastolic pressure, left-ventricular end diastolic pressure (LVEDP), cardiac index, history of smoking, angina pectoris, diabetes, and previous myocardial infarctions. Of the 1,311 grafts in our study 291, or 22.2%, were occluded between 1 and 60 months after surgery. An analysis of each of the aforementioned variables showed that higher diastolic pressure and more extensive coronary arteriosclerosis were both significantly associated with graft patency.

In patients reexamined within a year after surgery graft patency was associated with higher cholesterol, higher diastolic pressure, and taller height. In patients reexamined more than one year after surgery graft patency was related to smoking, more extensive arteriosclerosis, and heavier weight. The early seemingly protective effect cholesterol has on graft patency can be explained as follows: high cholesterol predisposes to coronary arterial obstruction which in turn results in increased coronary collateral circulation. The increase in collateral circulation allows for more flow to the myocardium once the obstruction has been bypassed. So when the vein graft is installed, the flow through the graft is increased and so graft patency is enhanced.

Previous studies have shown that graft patency is related to several variables. Patency rates one year after surgery are about 75 to 85 percent. Not surprisingly postoperative episodes of angina quite often followed graft occlusion. Exercise testing has been used by some investigators to show the value of the bypass procedure by postoperative improvement in reaction to stress. But other hemodynamic variables such as left-ventricular function, cardiac index, and LVEDP have been studied and no relationship to graft patency has been found. Intercoronary collateral circulation is enhanced in patients with occluded grafts but the collaterals seem to disappear in patients with patent grafts. There have been several studies of graft patency with respect to the artery bypassed. Most of these have failed to show any relationship but some studies have found significant differences. By and large the major determinants of graft patency seem to be intraoperative graft flow and size of coronary artery diameter with high flow and large diameters being associated with increased graft patency.

In summary several variables concerning postoperative cardiac fitness have been shown to be related to graft patency but only three preoperative risk factors have been shown to be associated with graft patency: (1) large coronary artery diameters [shown in other studies], (2) higher diastolic pressure, and (3) more extensive coronary atherosclerosis [shown in our study].

The continuing importance of scalene node biopsy in lung cancer patients

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• The records of 251 consecutive patients with newly diagnosed lung cancer were reviewed. Twenty-eight presented with significant cervical adenopathy, which nearly always indicated metastatic disease (25 of 28). One hundred seventeen patients without palpable cervical lymph nodes had scalene node biopsies, and 26 (22%) revealed metastases. Small cell anaplastic carcinoma and adenocarcinoma most frequently metastasized to scalene nodes (8 of 19 and 12 of 29, respectively) while squamous cell carcinoma seldom did (2 of 47).

Cervical, scalene, and mediastinal lymph node biopsy, bronchoscopy, and cytology each accounted for about 10% of the diagnoses in this series. More than 50% of diagnoses were made by procedures requiring no more than a local anesthetic. The continued importance of safe, simple staging procedures, especially scalene node biopsy, in suspected lung cancer patients is stressed.

DANIELS[1] IN 1949 pointed out in a now classic paper that scalene lymph node biopsy could detect metastatic disease in some lung cancer patients who had no palpable cervical nodes. These patients were clearly not candidates for further surgery.

Curiously, today, more than a quarter century later, the merit of scalene node biopsy in patients with suspected lung cancer is in dispute. Several authors[2-5] recently have belittled its value, arguing that (1) few scalene biopsies are positive unless there are palpable neck nodes, (2) immediate mediastinoscopy is the preferred diagnostic procedure, and (3) scalene node biopsy delays diagnosis. Other writers[6,7] make no mention of scalene node biopsy in the staging of lung cancer. Brantigan et al,[8] on the other hand, reviewed over 2,000 cases of scalene node biopsy in lung cancer patients without palpable cervical nodes and found a positive yield of 20%.

To focus light on the controversy we reviewed our recent experience at the Marshfield Clinic with patients having newly diagnosed lung cancer. Attention was directed toward the usefulness of scalene node biopsy in comparison to other staging procedures.

Materials and methods

The case records of 251 consecutive patients with newly diagnosed lung cancer over a 30-month period, from January 1973 to June 1975, were reviewed. Followup was 96% complete.

Data extracted from the charts included: (1) date of diagnosis, (2) date of last contact or death, (3) presence of palpable cervical lymph nodes on initial physical examination, (4) location of the tumor on the chest roentgenogram, the results of (5) cytology, (6) bronchoscopy, (7) scalene node biopsy, (8) mediastinoscopy, (9) thoracotomy, and (10) other biopsies or autopsy.

Staging procedures utilized during the study period included bronchoscopy, scalene node biopsy, mediastinoscopy, biopsy of palpable cervical nodes, biopsy of other metastases, and cytology. For patients who might benefit from surgical resection, bronchoscopy, scalene node biopsy, and mediastinoscopy were the most important. Bronchoscopy and scalene node biopsy were done under local anesthesia the day after admission to the hospital; and if further surgery was indicated, mediastinoscopy and possible thoracotomy were scheduled for the following day under general anesthesia.

Scalene node biopsy was done in patients with suspected lung cancer except when: (1) significant palpable cervical nodes were present, in which case these were biopsied; (2) bronchoscopy revealed an inoperable cancer which could be biopsied; (3) a bloody pleural effusion was present which showed a positive cytology; (4) obvious other metastases could be biopsied; (5) the patient was severely debilitated with advanced cancer or intercurrent disease; or (6) a coin lesion under 4 cm in diameter was present, in which case thoracotomy was done without prior staging.

Results

There were 251 patients in the series: 195 males (78%) and 56 females (22%). The median age at diagnosis was 66 years for males and 62 for females. The most common cell types were squamous cell carcinoma in males (40%) and

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adenocarcinoma in females (45%) (Table 1).

Staging procedures led to the diagnosis in 125 patients (50%), while thoracotomy was done in 73 patients (29%) (Table 2). Fifty-three patients (21%) were too ill for complete staging, and their diagnosis was made by cytology (25 patients, 10%), by roentgenogram and clinical criteria (20 patients, 8%), or at autopsy (8 patients, 3%).

Two hundred thirteen patients (85%) had no palpable cervical nodes at the time of diagnosis. Thirty-eight patients (15%) had palpable cervical nodes; in 28 biopsy was done, while in 10 the nodes were clinically insignificant and biopsy was not done. Twenty-five of the 28 biopsied cervical nodes (89%) were positive for metastatic cancer (Table 3). Patients with small cell anaplastic carcinoma were most likely to have significant cervical nodes at the time of diagnosis (12 of 50, or 24%), while patients with adenocarcinoma were least likely (3 of 60, or 5%). The frequencies for squamous cell and large cell anaplastic carcinoma were 9% and 11% respectively.

Scalene lymph node biopsy was done in 117 patients, none of whom had significant palpable neck nodes. Metastatic cancer was present in 26 (22%). There was a marked difference among cancer cell types metastatic to scalene nodes (Table 4). Small cell anaplastic (8 of 19, or 42%) and adenocarcinoma (12 of 29, or 41%) had the highest rates. Squamous cell carcinoma seldom yielded a positive scalene node (2 of 47, or 4%). The rate was intermediate in large cell anaplastic cancer (3 of 18, or 16%).

Mediastinoscopy was done following negative scalene node biopsy in 63 cases and revealed metastases in 20 (32%). Small cell anaplastic again had the highest yield (4 of 10, or 40%), with squamous cell (9 of 28, or 32%), and large cell anaplastic (6 of 16, or 38%) nearly as high. Only one case in 10 (10%) was positive in adenocarcinoma (Table 5).

Mediastinoscopy was done in 19 patients without prior scalene node biopsy, and 7 of these revealed metastases (37%). The highest frequency of positivity here was in adenocarcinoma (4 of 9, or 44%).

Ninety-nine patients have been followed for 24 months or more. Seventy were inoperable at the time of diagnosis, and of these 65 (93%) are dead. Thirteen of 29 patients (45%) in whom a resection was done are still alive.

Table 1—Lung cancer: 251 consecutive cases; sex and cell type

Cell Type	*Males*	*Females*	*Totals*
Squamous cell	78 (40%)	10 (18%)	88 (35%)
Adenocarcinoma	35 (18%)	25 (45%)	60 (24%)
Small cell anaplastic	38 (19%)	12 (21%)	50 (20%)
Large cell anaplastic	25 (13%)	2 (4%)	27 (11%)
Other cancer*	19 (10%)	7 (13%)	26 (10%)
TOTALS	195 (100%)	56 (100%)	251 (100%)

*Cylindroma (1), sarcoma (1), unclassifiable anaplastic carcinoma (4), and 20 patients in whom a histologic diagnosis was not made (16 males, 4 females).

Table 2—How lung cancer was diagnosed

	Frequency	*(Percentage of Total)*
Thoracotomy	73	(29%)
Mediastinoscopy	26	(10%)
Supraclavicular node	25	(10%)
Scalene node	26	(10%)
Bronchoscopy	30	(12%)
Cytology (sputum and pleural fluid)	25	(10%)
Other biopsy*	18	(7%)
Autopsy	8	(3%)
Clinical and x-ray diagnosis only	20	(8%)
TOTAL	251	(100%)

*Rib or bone (4), skin (2), open lung (2), "chest wall" (1), pleural (6), craniotomy (2), and bone marrow (1).

Table 3—Cervical lymph node biopsy

Cell Type	*Frequency*	*(Percentage)*
Squamous cell	8/9	(89%)
Adenocarcinoma	3/3	(100%)
Small cell anaplastic	11/12	(92%)
Large cell anaplastic	3/4	(75%)
TOTAL	25/28	(89%)

Discussion

Eleven percent (28 of 251) of our patients had clinically significant cervical adenopathy when diagnosed, and nearly 90% of these nodes contained metastases. This agrees with Baird's findings[9] in 286 postmortem examinations of patients with lung cancer. One hundred seventeen patients with no clinically significant neck nodes had scalene biopsies, and 26 (22%) revealed metastases.

Some authors made no distinction between supraclavicular and scalene lymph nodes, perhaps leading one to assume there is no difference. We believe these are two totally different lymph node areas. Nodes in the scalene fat pad lie below and medial to the supraclavicular nodes, and are beyond the reach of palpating fingers. A

complete scalene fat pad biopsy extends into the upper mediastinum and includes nodes which lie directly along the path the lymph takes from the lung to the systemic circulation. None of the cervical lymph nodes drains lymph from the lung,[10] so that when these nodes contain metastatic cancer, either the lower lymph channels are blocked or widespread metastasis has occurred. These facts have not been sufficiently emphasized in the past.

There are marked differences in the frequencies with which different cell types metastasize to cervical, scalene, and mediastinal lymph nodes. Patients with small cell anaplastic carcinoma frequently have metastases in one of these areas when diagnosed (up to 40%). Patients with adenocarcinoma seldom present with palpable neck nodes (5%), but often have metastases in scalene nodes (41%). Nine percent of patients with squamous cell carcinoma have palpable neck nodes, but few have positive scalene nodes (4%). The lymph nodes most likely to contain metastases in patients with squamous cell or large cell anaplastic carcinoma are those obtained at mediastinoscopy.

Immediate mediastinoscopy in lung cancer patients may well give a higher yield of metastases than scalene node biopsy. However, mediastinoscopy must be done under general anesthesia, whereas scalene biopsy can be done under local anesthesia and carries an insignificant risk to the patient. While mediastinoscopy has been a safe procedure for us and others,[11,12] its potential hazards are well known[12-15] and its routine use in diagnosing lung cancer is questionable.[15]

More than 50% of patients can be shown to be inoperable through staging procedures requiring no more than a local anesthetic. In our hands approximately equal percentages, about 10%, are diagnosed by either bronchoscopy, supraclavicular node biopsy, scalene node biopsy, mediastinoscopy, or other biopsies. Since lung cancer remains a devastating disease with few cures,[16] we feel that staging procedures requiring general anesthesia (mediastinoscopy, Chamberlain mediastinotomy, thoracotomy) should be avoided if metastases can be demonstrated by simpler, safer techniques.

We disagree with those who ignore or downgrade the value of scalene node biopsy. We stress its continued importance in selected lung cancer patients, because (1) we find 22% are positive when no neck nodes are palpable; (2) it can be done quickly and safely under local anesthesia; and (3) if it is negative, mediastinoscopy and possible thoracotomy can be scheduled for the next day, necessitating a maximum of only one general anesthetic for any patient.

Table 4—Scalane node biopsy

Cell Type	*Frequency*	*(Percentage)*
Squamous cell	2/47	(4%)
Adenocarcinoma	12/29	(41%)
Small cell anaplastic	8/19	(42%)
Large cell anaplastic	3/18	(16%)
Other*	1/4	(25%)
TOTAL	26/117	(22%)

*Unclassifiable anaplastic carcinoma (1), sarcoma (1), cylindroma (1), no histologic diagnosis made (1).

Table 5—Mediastinoscopy following negative scalene node biopsy

Cell Type	*Frequency*	*(Percentage)*
Squamous cell	9/28	(32%)
Adenocarcinoma	1/10	(10%)
Small cell anaplastic	4/10	(40%)
Large cell anaplastic	6/13	(46%)
Other*	0/2	(0%)
TOTAL	20/63	(32%)

*Sarcoma (1), cylindroma (1).

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Spontaneous closure of ventricular septal defects following pulmonary artery banding

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• **Two cases are presented in which spontaneous closure of a ventricular septal defect occurred following pulmonary artery banding. The patients remain with an iatrogenic cardiac anomaly and may require a second operative procedure in the future.**

SPONTANEOUS CLOSURE of ventricular septal defects (VSD) was first reported in 1918[1,2] and was documented by serial cardiac catheterization in 1958.[3] It has been estimated to occur in 25 to 45 percent of ventricular septal defects present early in infancy.[4,5] The fact that there can be "natural repair" of a major intracardiac defect must be taken into serious consideration when decisions are made to perform early open heart repair or palliative pulmonary artery banding. This paper reports two cases in which large ventricular septal defects closed spontaneously following banding of the pulmonary artery. The patients thus remained with intact ventricular septum but with iatrogenic pulmonary stenosis due to the band. These operative-induced anomalies probably will require eventual surgical intervention for relief of the obstruction.

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Figure 1—Angiogram in Case 1. Injection of dye into left ventricle with patient in the lateral position. Note the large ventricular septal defect (arrows) in the muscular portion of the interventricular septum. RV = right ventricle. LV = left ventricle.

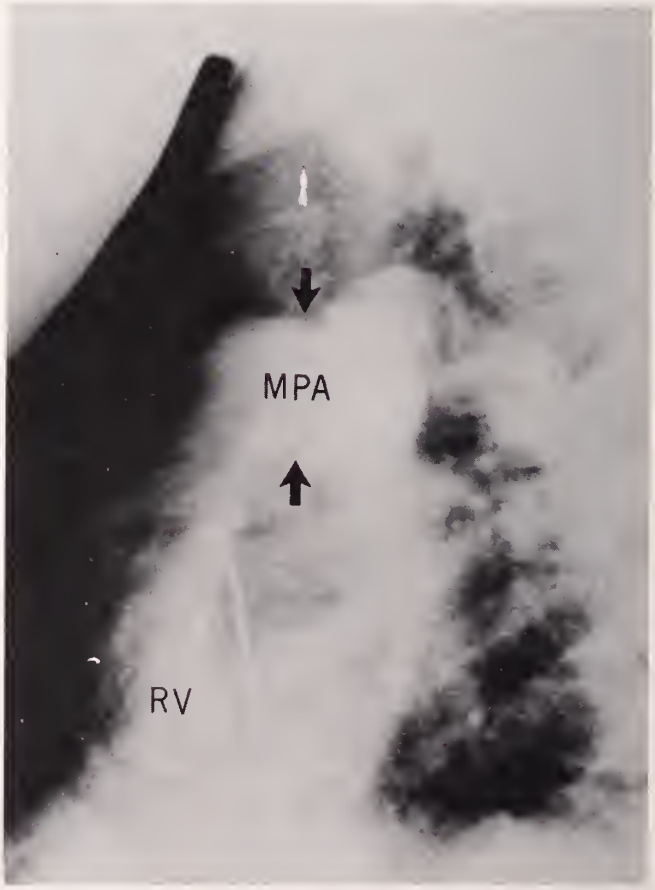


Figure 2—Angiogram in Case 1 following pulmonary artery banding and spontaneous closure of ventricular septal defect. Arrows delineate constriction in the pulmonary artery at the site of the band. RV = right ventricle. MPA = main pulmonary artery.

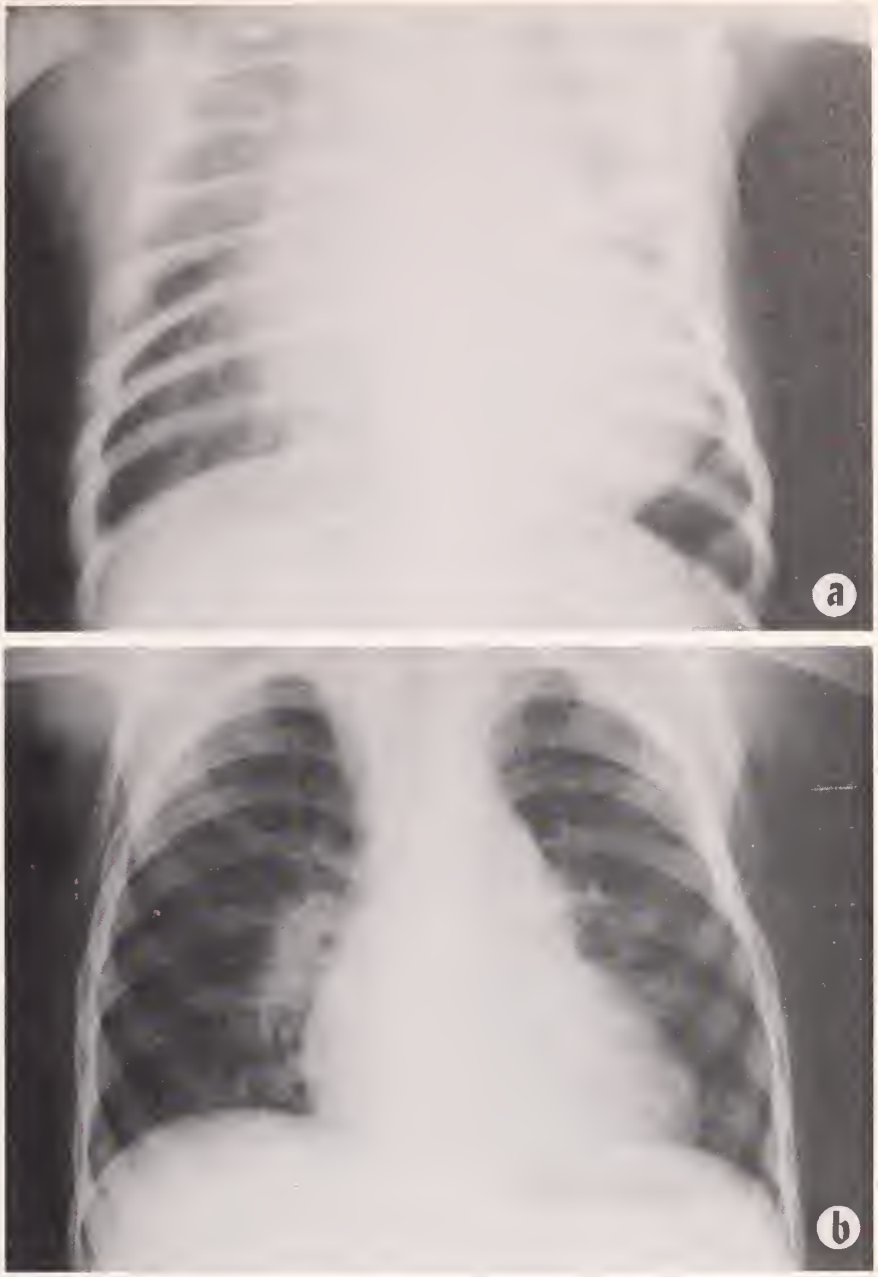
Case reports

Case 1. A male infant underwent cardiac catheterization at age five months because of chronic congestive heart failure and failure to thrive. His weight was only 8 lb 4 oz. The catheterization study revealed a large muscular ventricular septal defect with pulmonary artery hypertension (Fig 1). The pulmonary artery pressure was three-fourths of systemic pressure. There was no response to digitalization and diuretics. In view of the persistent failure he underwent a pulmonary artery banding procedure. Following a stormy postoperative course he showed gradual improvement and no longer required diuretics. Growth and development were within normal limits.

At the age of five years he reentered the hospital for a repeat catheterization in anticipation of open heart surgery to close the septal defect and remove the pulmonary artery band. The repeat study revealed an intact ventricular septum due to spontaneous closure of the VSD and a moderate constriction in the region of the pulmonary artery band (Fig 2). The right ventricular pressure was 62 mm Hg, or 60% of systemic pressure.

Case 2. A male infant was hospitalized at age two weeks because of severe congestive heart failure and absent femoral pulses. The cardiac catheterization showed the presence of a coarctation of the aorta, patent ductus arteriosus, and ventricular septal defect. There was marked pulmonary artery hypertension with the pressure equal to systemic pressure. The following day the patient was taken to surgery. The coarctation was resected, the ductus arteriosus divided, and the pulmonary artery banded.

The infant showed good response to surgery. Growth and development became normal. Cardiomegaly disappeared (Fig 3). He was readmitted for repeat elective catheterization at age four years. The study revealed spontaneous closure of the septal defect. There was a residual pulmonary artery band. Right ventricular pressure was only 52 mm Hg.



Figures 3a and 3b—Chest roentgenograms in Case 2 at time of first catheterization (3a) and second catheterization (3b). Note the marked reduction in cardiac size.

Comment

Prior to the use of deep hypothermia which made primary repair of ventricular septal defects in infancy possible,[6] pulmonary artery banding was the only surgical alternative for the infant with severe congestive heart failure. Results are dramatic and a successful banding allows the child to achieve normal growth and development. The banding procedure does have disadvantages which include development of subaortic stenosis and the reversal of a left to right shunt resulting in cyanosis. In addition, the eventual total repair of the septal defect is made more difficult in that the band also must be removed as part of the procedure.

The fact that spontaneous closure of a defect can occur even after a banding operation is performed makes the decision to band a very critical one. With spontaneous closure following banding, the patient is left with an iatrogenic abnormality. It is very possible that a residual band may result in progressive obstruction so that eventual surgery would be mandatory. Furthermore, while pulmonary artery banding has been largely replaced by primary open heart repair of VSD in infancy, many children may be subjected to unnecessary

high-risk surgery if their septal defect would have closed spontaneously. The problem is that at the present time it is impossible to predict which septal defects will undergo spontaneous closure. Size and position of the defect are of no help in making this prediction.

In view of the fact that spontaneous closure does occur even following palliative surgery, it behooves the cardiologist and cardiac surgeon to be very conservative about recommending a high-risk surgical procedure unless severe congestive heart failure persists or the septal defect is associated with other complicating intracardiac abnormalities such as transposition or double outlet ventricle. There is no surgical procedure which can match the results achieved by nature in producing a spontaneous closure.

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ABSTRACT WISCONSIN AUTHORS

Can the frequency of myocardial infarction be reduced during coronary artery operations?

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Ann Thorac Surg 23:14-19 (Jan) 1977

A prospective experiment was performed in patients—matched according to number of bypass grafts—to determine whether those having a glucose-insulin-potassium (GIK) perfusion during the procedure would have fewer infarctions compared with patients given a Normosol-R as a control perfusion.

Except for patients having ventricular aneurysmectomy or valve replacement, all patients undergoing myocardial revascularization were eligible for the study. Diabetes mellitus did not exclude any patient. Informed consent was obtained.

The GIK perfusate contained 1.6 gm of glucose, 2.1 units of insulin, and 1.7 mEq of potassium chloride (KCl) per kg of body weight. The GIK was mixed in an intravenous bottle, and sodium bicarbonate added to make the pH 7.4. The solution was infused for three minutes after bypass was begun and before the first aortic cross-clamping, done at 30 C.

The control perfusate was Normosol-R (pH 7.4), containing 4 mEq of KCl per liter but no glucose or insulin. The hemodilution factor was 16 ml per kg of patient's body weight in the GIK and control groups. Control patients were given additional potassium during the operation by the anesthesiologist, depending upon the serum potassium concentration.

Conduct of the operation was standardized to include: (1) iced Ringer's slush in the pericardial cavity, (2) aortic cross-clamping for distal anastomoses, (3) three minutes of coronary perfusion following cross-clamping, (4) all distal anastomoses fashioned before the proximal anastomoses, and (5) warming begun during the last period of ischemia and continued while the proximal anastomoses were being performed.

Dextrostix® was used every half hour to spot-check blood glucose in GIK patients. Also, blood glucose was determined chemically.

In terms of enzyme concentrations, two distinct groups of patients could be identified—those who had a myocardial infarction and those who did not. The most specific of the cardiac enzymes, creatine phosphokinase-MB (CPK-MB) isoenzyme, differentiated these two groups of patients. Our definition of myocardial infarction was a 24-hour CPK-MB isoenzyme value of 100 IU or greater per liter. Six patients (11%) had such a value. Four myocardial infarctions (13%) occurred in the control group of 31 patients, and 2 (8%) in the 25 patients in the GIK group. The double-graft recipient who received a GIK perfusion and had myocardial infarction did so because of technical difficulty arising during an attempted graft to the superior obtuse marginal branch of the circumflex artery; this graft had to be abandoned. Excluding this patient, the myocardial infarction rates were 13% for control patients and 4% for the GIK group.

Early in our experience it was noted that GIK-perfused patients frequently defibrillated spontaneously at the end of the procedure, and this is confirmed by our total experience. That is, 9 of 25 (36%) of GIK-infused patients defibrillated spontaneously. The corresponding rate for control perfusion was 2 of 31 (6%) of patients.

Whether intraoperative GIK increased myocardial protection remains an open question. These early studies did show a lessened incidence of myocardial infarction as well as more frequent spontaneous defibrillation in the GIK group, suggesting that GIK may have been beneficial. ■

End-to-end jejunoileal bypass for morbid obesity: the psychosocial outcome

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• As part of an ongoing study of the intestinal bypass procedure for morbid obesity at the University of Wisconsin, the psychosocial response and adaptation of the first 30 patients were examined. Results are discussed in light of other published series, recommendations made for selection of candidates, and suggestions given for postoperative management.

THE USE OF A jejunoileal bypass for the amelioration of intractable obesity is meeting with increasing professional acceptance.[1-3] From the outset the importance of psychosocial factors in successful outcome has been recognized and the literature offers testimony to the fruitful collaboration between surgeon and psychiatrist. Our retrospective study of 20 of the first 30 patients in the Wisconsin series was undertaken to clarify: (1) If certain life experiences could be correlated with psychosocial outcome, and (2) If certain postoperative experiences could be related to psychosocial outcome. The surgical results on this sample were reported earlier in this journal.[4]

Materials/Methods

An attempt was made by letter and telephone to the first 30 patients in the Wisconsin series. Twenty responded positively. Three refused participation. Two had moved and were willing to participate but could not make travel arrangements. Three could not be located. One was in prison. One patient had had her bypass revised (liver disease) and thus was dropped from consideration. A review of inhospital and followup materials lead us to believe this sample was representative of the entire group.

The patients, and in 12 cases their spouses as well, participated in separate semistructured interviews of 1.5 to 2.5 hours duration. We focussed on one year experience before surgery, the decision to have the surgery, and postoperative experiences. Information was supplemented via charts and staff personnel who knew the patients. In a few instances information was used (with patient consent) from psychiatric consultations which had been requested for postoperative difficulties. The Minnesota Multiphasic Personality Inventory (MMPI), The Eysenck Personality Inventory (EPI), and Moody Problem Checklist were administered at the time of interview.

We wished to make some assessment of psychosocial outcome and decided to use the following clinical rating scale based on interview and testing materials. Zero to 3 points were awarded based on (a) satisfaction with weight loss, (b) absence of untoward psychiatric symptoms, (c) absence of distress and limitation imposed by side effects (*ie*: diarrhea), and (d) improvement in social and interpersonal function. Thus a "perfect" outcome score would be 12 points.

Results

Our patients seemed to fall into two groups when their personal backgrounds were reviewed. The first and larger group, Group A, resembles the group described by Bruch[5] and the low psychopathology subgroups of Atkinson and Ringuette's study.[6] Briefly, those in this group (N=14) came from stable families with a high prevalence of obesity. They recall their home environment as "close" or restrictive, where a premium was placed on cohensiveness through the avoidance of open expression of anger. These patients recall conflicts and rivalries but rarely link these to the genesis of their overweight. Eating in response to stress was modal in these families. Leaving home was accomplished with great difficulty, and for many familial ties remain close and conflicted. By and large these patients are or have been married, have children, report satisfaction if not enjoyment with current sexual activity, and have received little psychiatric attention.

There is a smaller group (N=6), Group B, whose past experience most resembles Fink's group of superobese patients,[7] and Castelnuovo-Tedesco's group of bypass patients.[8] These persons come from a chaotic family experience: divorces, alcoholism, sexual molestation—from which they received little nurturance and about which they are quite bitter. In many instances they served as "stand-in parents" for their siblings and as a consequence are angry at having "missed what was due me." These patients strive to be independent of others' influence while longing to be cared for. Most have never married preferring relationships which are short-lived and functional. There is much sexual difficulty in this group as well. Many spontaneously link

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Table 1—Patient characteristics

Patient	Age at surgery	History	Preoperative weight	Percentage over desirable weight**	Average weight loss per month for first year	Outcome score
1*	51	A	380	111	20	12
2	45	B	321	138	22	5
3	33	A	381	181	20	9
4	44	B	405	148	12	3
5	32	A	249	133	14	7
6	26	A	398	178	15	7
7	29	A	297	151	12	7
8	23	A	388	164	12	8
9	42	A	283	110	7	9
10	36	A	485	217	18	6
11	29	B	333	150	12	7
12	29	A	324	131	10	11
13	34	A	402	298	10	8
14	38	A	314	145	10	8
15	45	A	402	256	12	8
16	28	A	510	177	19	9
17	21	B	391	190	17	5
18	23	B	312	92	13	10
19	22	B	319	136	11	2
20	29	A	214	144	6	11
21	31	B	327	156	9	8

* male.
** see reference 12.

these early experiences to the genesis and maintenance of their obesity.

Initial weight and rate of weight loss related to outcome

It has been reported elsewhere[9] that patients who are initially the most overweight lose the most weight and lose it more rapidly than those nearer their desirable weight. Also it has been suggested that rapid weight loss is associated with more psychological distress.[10]

We examined the six fastest and six slowest weight losers in our sample and found no statistically significant relationship between rate of weight loss and outcome. However, there was a trend towards better outcome in the group that lost weight more slowly (all outcome scores were average or above) and three of the five fast losers had outcome scores below average. Our best and poorest outcome patients were in the fast-losing group, however. There was a slight tendency for the most initially overweight to lose more rapidly during first year but this was not as pronounced as in Salmon's study.[9]

Outcome as a function of the A/B variable

The six high outcome and six low outcome scorers were ranked. A Chi-square, corrected for continuity, was applied with one dimension contrasting (high *vs* low score) and the other dimension presence or absence of the A/B variable. Results were not statistically significant (p-0.50). However, a majority of type B patients in the study fell within this poor outcome subgroup.

Psychosocial response to the procedure

Both patients and their families found the immediate postoperative phase extremely stressful. This related primarily to the severity of physical side effects. During this period depression and affective lability were common. This phase is self-limiting and is followed by a generally positive phase characterized by new social, sexual, and vocational activity. The improvement in self-image and activity is impressive. Anxiety accompanies this new assertiveness but mood fluctuations seen in the first phase are less severe and less prolonged.

When weight stability is achieved, usually around the one-year mark, a third phase begins. The patients must come to terms with the limits of his/her abilities and with the realization that this is "it." At this point the greatest marital distress is seen. Some patients undertake a fundamental reassessment of their relationship and decide on a divorce. Others "renegotiate" with their spouses the terms of their marital agreement now that they feel and behave like "new" people. The relationship finds a new balance in terms of sexuality, autonomy, and assertiveness. The vicissitudes of this phase are detailed more fully elsewhere.[11]

Unmarried patients who have hoped the weight loss would solve conflicts about intimacy and sexuality often are faced with the fact that they are "still the same" in this respect. This latter pattern was seen more in the Type B patients. We feel this discovery is the major reason for their relative dissatisfaction with the procedure. In other words those patients who achieve a major and lasting improvement in their personal relationships, by and large the Type A patients, are willing to tolerate the residual physical side effects of the procedure.

Discussion

A clear majority of our patients were satisfied with the results of the bypass procedure. All but two in our sample said that they would repeat the procedure if given the opportunity to do so. The incidence of major psychiatric complications in this group was surprisingly low considering the high incidence of psychiatric morbidity reported in the superobese.[7] Our results show a trend towards greater and more rapid weight loss among those patients who initially are the most overweight. This is in agreement of our published studies.[9] There also is a tendency, below the level of statistical significance, for rapid weight loss to be associated with a poorer psychosocial outcome.

Although we can add no psychiatric contraindications to those of acute psychosis and acute depression, we feel we have identified

a subgroup of acceptable candidates who must receive extra attention. They are those patients whose early life experience has been characterized by a *relative* lack of stable personal relationships which is reflected in their preoperative life style. These patients initially appear the more independent and assertive and yet come to grief in the end. The physician must be alert for signs of depression, neglect of routine, and noncompliance. Directness in questioning is of use here. Direction rather than "insight" appears to be the keynote for management, for this group displays little tendency for self-reflection and insightfulness.

It also appears that the effects of the surgery have implications for the patients' families as well. Much of the patients' difficulty postoperatively involves the family system, and this important factor has received scant attention in the literature. Our findings in this area have been documented elsewhere.[11]

In summary, we wish to alert clinicians to a group of high-risk predictors for patients undergoing an intestinal bypass for morbid obesity. They are: (a) rapid weight loss with attendant side effects, (b) presence of a history of unstable life-styles and relationships, and (c) the development of marital strife and disharmony. Attention to these factors can improve psychosocial outcome in this procedure which often is a life-saving last chance for persons crippled by morbid obesity.

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ABSTRACT WISCONSIN AUTHORS

School-hospital affiliations: a balancing of interests

BURTON A WAISBREN, MD, Milwaukee, Wis: *Hosp Pract* 12:117 (June) 1977

Doctor Waisbren makes the following points in his article: Affiliations between medical schools and hospitals are inevitable and necessary; for these affiliations to be successful, negotiations between those who represent six spheres of interest are necessary. No. 1, the university must protect its faculty in regard to opportunities for clinical growth and the opportunity to make a fair income. However, the university cannot expect to make income from the affiliation with which it intends to pay for teaching and research. The university cannot expect to use the community hospital as a feeder facility at the expense of the community hospital's development. The clinical professorship should be issued on the basis of credentials rather than on the basis of total compliance to the university program.

No. 2, the hospital board will have to be willing to open the books on the affiliation agreement so all can see the manner in which the affiliation is being financed. No. 3, the private physicians, particularly those with specialist training who are consultants, must be assured only fair competition from professors assigned by the university. The practicing physician must protect his primary relationship with his patient, often in the face of patient visits by a multitude of other physicians. To accomplish this and protect their interests, private physicians will have to develop staff structures independent of hospital board appointees or university control.

No. 4, the patient must protect his right to be treated by the physician of his choice, in the manner of his choice. If house staff is to *write* all orders, it must be with the patient's knowledge and acquiescence. If the surgical resident is to do any or all of the operation, the same must hold true. The patient must have assurance that he is not the unknowing philanthropist who is supporting the teaching program and research, by having the hospital books open to him. No. 5, the third party payer has a responsibility to be able to assure his customer, the patient, that his payments are, in fact, going solely for his medical care. The argument that taking part of the payments "off the top" to support teaching or research will improve medical care in a community or university hospital is attractive, but must be proved before it is acceptable.

No. 6, the administrator appears to be the natural arbitrator between the university, the medical staff, the hospital board, the patient, and the third party payer, but he can only do this when he can achieve some sort of professional status that makes him professionally independent of the hospital board. ■

Diverticular disease of the colon

Fredric Jarrett, MD, Madison, Wisconsin

APPROXIMATELY 20% of patients aged 40 years and 40% of those age 70 have colon diverticula demonstrable by barium enema. Ninety percent of patients with colon diverticula have involvement of the sigmoid colon, and in about 80% of patients with diverticulosis the pathology is limited to the sigmoid and descending colon. The diverticula are usually found between the mesenteric and lateral taenia where the largest nutrient vessels penetrate the inner circular muscle.

How do we identify those patients whose diverticulosis is symptomatic? When do we advise patients with symptomatic diverticulitis to undergo elective operation before perforation, obstruction, or fistula formation occurs? The recognition and management of diverticular disease and its symptoms can challenge the most experienced internist and the operative therapy of the complications of diverticulitis will demand the utmost surgical skill.

Pathogenesis

For herniation to occur, there must be increased intralumenal pressure as well as a weakness in the colonic wall. The intralumenal pressure of the normal resting sigmoid colon is close to atmospheric pressure, as is the resting pressure in a colon containing diverticula. Small positive pressure waves occur at regular intervals but do not cause effective peristalsis toward the anus. However, in persons whose colons contain diverticula there is an increase in the frequency and magnitude of spontaneous contractions. Cineradiography also reveals that very high intralumenal pressures are generated by "segmentation" in which transverse muscular contractions convert the sigmoid from a tubular shape to a series of small bladders, each with its outflow obstructed. Parenteral morphine exacerbates the usual increased intralumenal pressure when given to persons with diverticula and thus should not be given during an attack of acute diverticulitis; meperidine (Demerol®), which lowers the intracolonic pressure, is preferable. The pressures that are generated within these segments may produce mucosal herniation through the muscular layers of the colon. Operative or autopsy specimens of colon containing symptomatic diverticula reveal thickening and enlargement of the colonic muscle layers and it is now believed that muscular thickening and abnormal pressure relationships precede the appearance of diverticula and account for many of the symptoms previously attributed to diverticulitis.[1] In fact, about 30% of colons resected for what is clinically considered diverticulitis contain no evidence of inflammation whatsoever.[2,3]

Diverticular disease is virtually unknown in most underdeveloped countries, but it affects a significant portion of the population of more affluent western nations, where dietary styles are high in carbohydrate and protein and low in unrefined fiber. An increase in diverticular disease has been seen in American blacks concomitant with the diminished intake of corn, and in Orientals living in Hawaii as compared with those in Japan. It is postulated that a low-residue diet favors the development of diverticula by augmenting the tendency to segmentation and mucosal herniation and increasing transit time. A colon that must pass larger, softer stool has a larger caliber and segments less efficiently, thus generating less intralumenal pressure, and decreasing the tendency to develop diverticula.

Clinical presentations

The variation in clinical presentations of patients with diverticular disease is wide. The simplest and most common is that of mild *left lower quadrant discomfort,* sometimes precipitated by dietary or emotional factors, and often associated with minor changes in bowel habits. This picture often has been referred to as "spastic colon" or the "prediverticular state" for want of a better term. It was noted several

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Co-Editors—

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years ago that a large percentage of symptomatic patients with diverticulosis had undergone barium enema studies several years before the diverticula had been demonstrated and had received the diagnosis of "irritable colon syndrome."[4]

Such patients can be treated with stool softeners or agents which increase the bulk of the stool such as psyllium hydrophilic mucilloid (Metamucil®). In addition, a high-fiber diet affords significant symptomatic relief which increases over a three-month period.[5] Mild antispasmodics containing low doses of phenobarbital and an atropine derivative are helpful as well. It was previously believed that attacks of diverticulitis were caused by episodes of inflammation within diverticula and produced similar symptoms. We now realize that diverticulitis is caused by perforation of single or multiple diverticula and the resultant local inflammatory reaction—thus, peri-diverticulitis would be a more accurate term. The way in which the perforation is contained within the peritoneal cavity determines the patient's course.

A perforation that is rapidly sealed by adherence of pericolic fat or appendices epiploicae may cause only minimal toxicity and no systemic or local reaction. In this circumstance bed rest, mild analgesia, and stool softeners may be sufficient initial therapy, followed by appropriate dietary modifications. On the other hand, a mesocolic or pelvic abscess may result, and be manifest by systemic toxicity, low-grade fever, and vague changes in bowel habits. Sigmoidoscopy rarely shows evidence of an inflammatory process within the bowel lumen because the visible pathology is an extracolonic mass. The usual finding on sigmoidoscopy is inability to advance the instrument above the peritoneal reflection because of spasm and angulation of the distal sigmoid. Diverticula themselves are rarely visualized by sigmoidoscopy. Barium enema often reveals evidence of diverticular disease without elucidating the precise nature of the problem since the roentgenographic manifestations of diverticulitis are almost exclusively extracolonic. We recently cared for a patient who had a normal sigmoidoscopy and barium enema as part of a work-up for three episodes of *Bacteroides* sepsis and who, at laparotomy, was found to have a perivesical abscess caused by a ruptured sigmoid diverticulum.

Patients with minimal evidence of peritoneal irritation—localized tenderness, fever, leukocytosis, and a tender mass—can be hospitalized and treated by bed rest, nasogastric suction and parenteral antibiotics. Their response to this therapy is usually rapid with diminished tenderness, fever, and distention, a declining erythrocyte sedimentation rate, and a return of the white blood cell count to normal; and they can be discharged from the hospital several days later after diet has been resumed. I believe that these patients who have been hospitalized with an inflammatory mass secondary to diverticulitis should be seriously considered for elective sigmoid resection, since the mortality and morbidity of properly performed *elective* surgery for diverticulitis are minimal.

"The recognition and management of diverticular disease and its symptoms can challenge the most experienced internist and the operative therapy of the complications of diverticulitis will demand the utmost surgical skill."

Complications requiring operation

If a diverticulum ruptures into the urinary bladder, a colo-vesical fistula will develop—the most common type of fistula seen with diverticulitis. The excessively high pressures generated by the contracting colon as compared to the bladder tend to prevent spontaneous closure of the fistula.[6] Such patients will present with either pneumaturia or urinary tract infections with multiple enteric organisms. It is very difficult to demonstrate the fistula by either barium enema or cystogram, and cystoscopy usually shows only some bullous edema or inflammation of the bladder without showing the fistula opening itself. A useful tactic is to insufflate air into the sigmoidoscope during examination. A lateral film of the abdomen will then often show air in the bladder and the patient will experience pneumaturia, providing conclusive proof of the communication between the colon and bladder.

It was previously believed that a colo-vesical fistula required an initial diverting colostomy to allow the inflammatory process to subside before definitive operation was undertaken. More recently, sigmoid resection has been accomplished safely without the need for the preliminary colostomy. I believe that resection of the area of the sigmoid and bladder containing the fistula can be safely undertaken if the inflammatory process is well-localized in otherwise healthy patients. Catheter drainage of the bladder is necessary for about a week, and if any concern exists about the colon anastomosis, a complementary transverse colostomy can be constructed to divert the fecal stream, the colon anastomosis allowed to heal, and the colostomy closed several weeks later. Colovaginal fistula is less common, and colocutaneous fistula is seen almost exclusively in patients who have undergone previous colon operations.

The most lethal of the presentations of diverticulitis is *free perforation with gross fecal peritonitis.* Vague abdominal symptoms are followed by the sudden onset of severe abdominal pain. On examination severe tenderness and rebound can be demonstrated and x-ray films often will show a pneumoperitoneum. These patients are usually elderly and tolerate peritonitis very poorly. They rapidly become hy-

povolemic from fluid losses into the peritoneal cavity and their peritonitis causes respiratory embarrassment. They must be prepared for emergency laparotomy with prompt insertion of large intravenous lines for replacement of fluid deficits, nasogastric suction, and commencement of parenteral antibiotics specific for coliforms and anaerobes. We usually prefer to monitor central venous pressure and to insert a Foley catheter into the bladder as well.

At laparotomy the operative procedure that is indicated depends upon the overall condition of the patient, the amount of fecal contamination in the peritoneal cavity, and the site of perforation. Complete diversion of the fecal stream and lavage of the peritoneal cavity are requisite. This is most simply accomplished with a completely diverting transverse colostomy, which is sometimes the only operation that an elderly and unstable patient will tolerate. With diversion of the fecal stream one hopes that the perforation will heal, allowing the sigmoid to be resected electively at a later date, and the colostomy closed as a third and final stage after the colon anastomosis has healed. The time-honored "three-stage" treatment of perforated sigmoid diverticulitis has resulted in a low mortality, but in a very prolonged total hospitalization and morbidity.[7,8] Theoretically, exteriorization of the perforation could be performed, but shortening of the sigmoid mesentery and the location of the perforations low in the pelvis usually make this option technically unfeasible. In practice, patients treated with transverse colostomy have an indolent course from additional fecal contamination in the colon segment distal to the colostomy, which tends to be difficult to evacuate. If the patient's condition permits, a preferable strategy is to quickly resect the segment of perforated colon, lavage the peritoneal cavity with copious quantities of saline, and exteriorize both the proximal and distal portions of colon. If the splenic flexure is mobilized, the proximal colon can be exteriorized as an end colostomy close to the distal colon, and eventual re-anastomosis will be facilitated.

Colonic bleeding from diverticula remains a difficult problem. Nevertheless, diffuse colonic diverticulosis is now the most common cause of exsanguinating hemorrhage in the elderly patient. The patients are usually elderly and have significant associated cardiorespiratory problems. Because of their age and infirmity they often are treated with an excessive number of transfusions before operation is advised. The site of bleeding often is impossible to localize preoperatively, and usually equally so at laparotomy. Intraoperative attempts to localize the bleeding site by multiple colostomies and introduction of sterile sigmoidoscopes are usually unsuccessful and result in fecal spillage, increased bleeding, and prolonged operating time. The results of operative exploration for bleeding colon diverticula have not been ideal and there is understandable reluctance on the part of physicians to recommend operation for this complication.

"Improved understanding of the pathology of diverticulosis has resulted in better results after operation for most of the complications of diverticulosis."

Baum and colleagues[9] have been very successful in using arteriography to localize the site of bleeding from colon diverticula. Hemorrhage must be at a rate of at least 0.5 ml per minute for the site of bleeding to be visualized angiographically. If the intra-arterial catheter can be positioned close to the bleeding vessel, bleeding can be controlled in over 90% of patients by the continuous infusion of vasopressin. In approximately two-thirds of cases bleeding does not recur and in the remainder, a valuable time period has been made available to replete lost blood and treat associated medical problems, allowing operation under more optimal circumstances. Should operation be necessary, a segmental colon resection is possible after the site of bleeding has been localized. If a bleeding site cannot be localized, and more than five or six units of blood are required in the face of continuing hemorrhage, an expeditious subtotal colectomy with anastomosis between the terminal ileum and rectum is preferable to a segmental colon resection.[10] Elderly patients tolerate this procedure extremely well, while they tolerate continued bleeding and fecal spillage into the peritoneal cavity very poorly.

Improved understanding of the pathology of diverticulosis has resulted in better results after operation for most of the complications of diverticulosis. Whether wider application of nonoperative therapy aimed at preventing muscular thickening and symptomatic diverticulosis will ultimately lower the incidence of the complications of perforated diverticulitis will be of great interest.

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Pneumatosis coli

Report of a case with perforation

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PNEUMATOSIS INTESTINALIS is an uncommon condition in which gas cysts develop within the wall of the gastrointestinal tract, and similar cysts have rarely been described in other abdominal locations. Pneumatosis coli is a term that is restricted to patients in whom the colon is affected without involvement elsewhere. The small intestine is the most common site of involvement. Although only approximately one case a year is reported, it is a diagnosis which should be kept in mind as it may respond to medical rather than surgical treatment.

Pneumatosis intestinalis (pneumatosis cystoides intestinalis or intestinal emphysema) was described in the human cadaver in 1730 with a complete description of an autopsy case being given in 1873[1] as noted by Reyna in 1973 when he reported 12 cases and discussed various etiologies. In 1952 Koss[2] reported an extensive review of 213 cases from the world literature. Mechanical, pulmonary, and bacterial etiologies have been suggested[1,3,4,5] with the additional possibility of increased permeability of the mucosa being considered.[6] The condition is to be differentiated from colitis cystica profunda in which the cystic spaces within the bowel wall are lined by mucosa (mucous cysts).

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The mechanical origin suggests that abnormal pressure forces air through tiny mucosal defects, perhaps into submucosal lymphatics along mesenteric vessels or via the submucosa and is then distributed in the submucosa by peristalsis. Sigmoid colon intraluminal pressures may exceed 90 cm of water,[7] and this would certainly encourage passage of gas through any such defects. It has been suggested that when pneumatosis intestinalis complicates a jejunoileal bypass, as has been reported,[8,9] that this is due to the ileal intraluminal pressure being about 70 cm less with a gradient capable of causing dissection at the ileosigmoid anastomotic line. It also has been reported after other potentially traumatic procedures such as sigmoidoscopy. The submucosal route also has been suggested for the rare involvement of the esophagus.[10]

The pulmonary origin was suggested 15 years ago.[3] Pneumatosis intestinalis developed in patients who had no demonstrable preceding gastrointestinal disease but had severe pulmonary disease. Air from ruptured alveoli has been shown previously to dissect along pulmonary vessels to the lung root and mediastinum; and it seems reasonable to postulate that this could subsequently pass through the mediastinum, into the retroperitoneal area, then dissect along the vascular supply of the viscera.

The bacterial origin suggests bacteria from the bowel produces these gas cysts. This is supported by its association with necrotizing enterocolitis in infants and pseudomembranous enteritis in adults. This also can be produced experimentally.

Case Report

A 93-year-old white male was admitted with the chief complaint of abdominal pain, distention, vomiting, and obstipation for several days prior to admission. He had no history of serious gastrointestinal complaints other than a change in bowel habits during the past several months. A fractured right femur four years before had been treated by internal fixation. The patient occasionally had been incontinent of urine.

On initial examination the patient revealed pallor, dyspnea on exertion, and dehydration. There were a few right basilar rales, and heart tones were clear with an occasional extra systole. The abdomen was distended, although not significantly tender and no masses were palpable. Bowel sounds were present. Initial laboratory studies showed a negative VDRL; hematocrit, 32%; hemoglobin, 11 gm%; Westergren erythrocyte sedimentation rate, 125 mm/hr; white blood cell count, 7,400 per cu mm with 1% band forms, 76% segmented neutrophils, 1% eosinophils, 21% lymphocytes, and 1% monocytes. Urinalysis: amber, slightly cloudy, specific gravity 1.012, pH 5, and chemistry tests normal. The spun deposit showed 6 to 8 white blood cells and an occasional red blood cell. His creatinine was 2.1 mg/100 ml; blood urea nitrogen, 89 mg/100 ml; glucose, 123 mg/100 ml; total protein, 6.9 gm/100 ml with lactic dehydrogenase and serum glutamic oxaloacetic transaminase slightly elevated. Venous blood showed a pH of 7.43; carbon dioxide pressure, 43 mm Hg; carbon dioxide, 31 mEq/liter, sodium 140 mEq/liter, potassium 2.7 mEq/liter, hydrogen bicarbonate ion 1.29 mEq/liter, acid/base ratio 1/23.3. Chest x-ray film revealed a tortuous aorta with calcification of its walls, lungs normal, normal bony structures, and a small amount of fluid in the costophrenic angle. Abdominal films showed two markedly distended loops of colon across the midabdomen. The

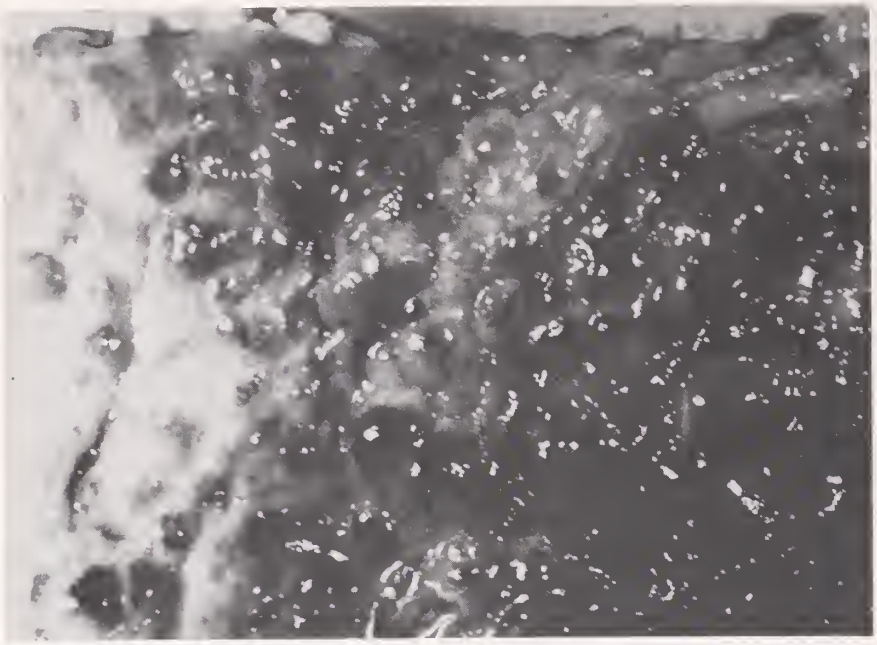


Figure 1—Pathologic studies of the exposed mucosal surface of the colon showed a striking cobblestone appearance with focal areas of red-to-purple hemorrhage.

walls of the larger loop had a mottled appearance due to gas in the muscular layers. There was no evidence of gas in the liver. Electrocardiographic studies were interpreted as abnormal with myocardial damage and 3° AV block.

Following preparation of the patient with hydration and correction of his electrolytes, a laparotomy was performed for obstruction of the descending colon. A left paramedian incision was made and a very markedly distended midcolon was evident. Further exploration revealed a section of descending colon of about 60 cm in length of grossly abnormal bowel. There was marked thickening of the bowel wall with what appeared to be multiple gas-filled cyst-like structures throughout the bowel wall and adjacent mesentery. In addition there was edema and the tissue was very fragile. The mesenteric arterial and venous circulation was intact. This area of the descending colon was resected and a colostomy was established. His postoperative course was eventful only because of the patient's age and cardiac condition, and his convalescence was complicated by his old hip injury. However, he was discharged after 10 days with a well functioning colostomy.

The pathology report noted marked intramural thickening from multiple gas-filled cysts along the mesenteric border, the wall being translucent. A perforation 0.9 cm by 0.5 cm was present adjacent to the mesentery. The cysts collapsed on section. The exposed mucosal surface had a striking cobblestone appearance (Fig 1) with focal areas of red-to-purple hemorrhage. Three areas of mucosal ulceration were noted. Microscopically cysts were noted beneath the serosa, in the musculature, but predominantly in the submucosa (Figs 2 and 3). The majority of cysts had no lining, but occasional cysts showed lipid filled histiocytes and rare multinucleated giant cells; and some submucosal cysts showed an acute or subacute inflammatory reaction around the edge. These submucosal cysts were adjacent to crypts lined by inflammatory cells. A Gram-stain (Brown and Hopp) showed a focal fibrin deposit on the mucosal and serosal layers with increased fibroblastic activity, and no bacterial content in the cystic areas.

Two months later the patient was rehospitalized with an acute myocardial infarction, and died. Autopsy showed no residual or recurrent bowel abnormality.

Comment

Gas cysts may produce intestinal obstruction, although the patient doesn't usually appear gravely ill unless associated with necrotizing enterocolitis. The condition may disappear spontaneously, but in other cases mortality has been high. Bypass operations or resection of the bowel are thought to be lifesaving.

Currently it is appreciated that these patients can be simply and effectively treated medically with the inhalation of oxygen. Forgacs[11] predicted that cysts could be deflated if the total pressure of gases in venous blood were lowered by prolonged breathing of a gas mixture containing a high concentration of oxygen and a low concentration of nitrogen; he proved this by treating a patient for six days in an oxygen tent with continuous breathing of 70% oxygen. Pure oxygen cannot be given continuously because of lung toxicity. Subsequently it was shown that intermittent oxygen therapy was successful. It is recommended that minimal periods of at least four hours of continuous oxygen should be given in order to maintain an adequate carbon dioxide pressure. A carbon dioxide pressure of about 300 mm Hg (40 kPa) can be achieved with 6 liters per minute of humidified oxygen via a standard mask together with 4 liters per minute by nasal catheter.[12] Response to treatment occasionally may be dramatic with complete cessation of bowel symptoms within 48 hours,[13] although treatment is usually maintained for 5 to 6 days to insure absorption of all gas-filled cysts.

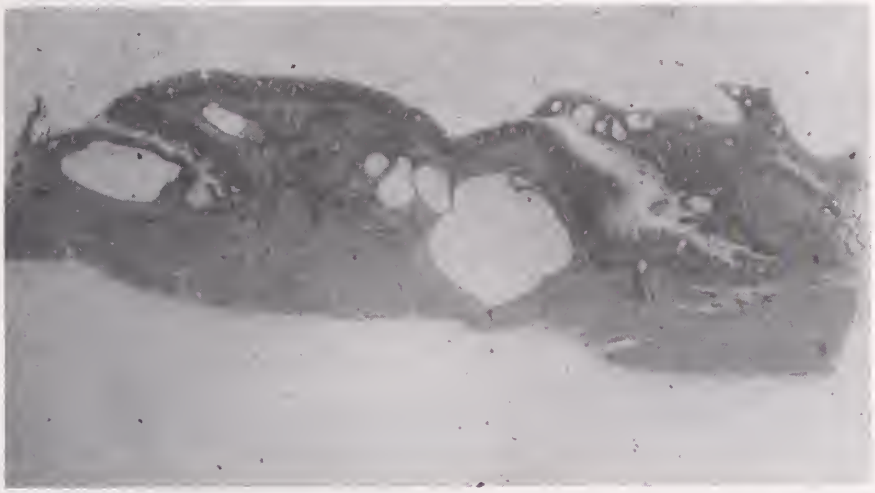
Summary

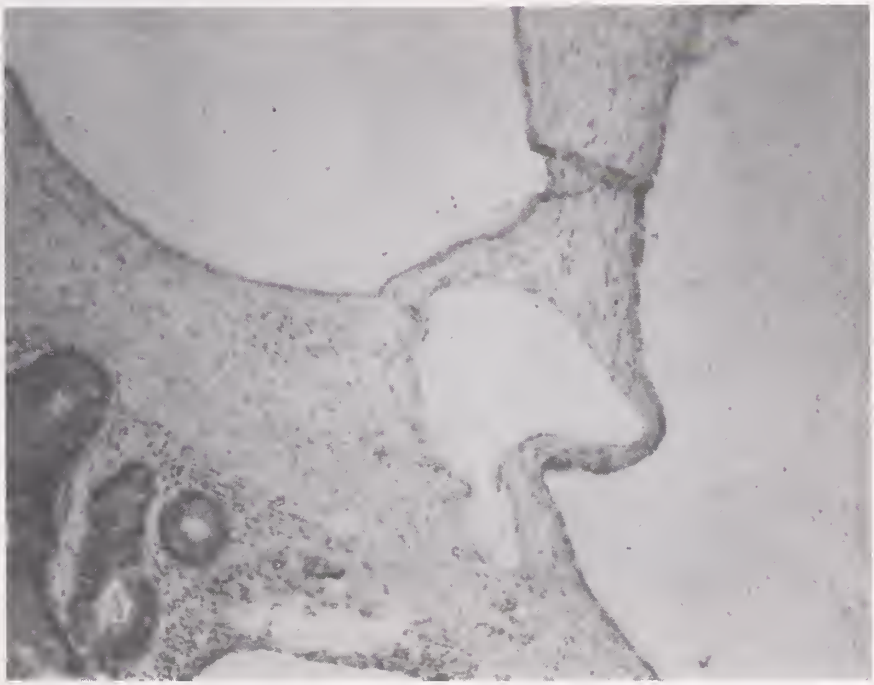
A case of pneumatosis coli is presented, the oldest patient with pneumatosis intestinalis found to date in the literature. Preoperative x-ray films had been difficult to interpret; and although gas had been identified in the wall of the colon, a diagnosis of pneumatosis coli was not established. Because of symptoms of progressive subacute obstruction, surgery was done and a segmental resection of the colon performed. Extensive pneumatosis coli was present within the segment of involved bowel, with a focus of perforation.

Breathing oxygen washes out nitrogen from the lungs and tissues leaving only oxygen and carbon

dioxide in arterial blood. Most of the oxygen is metabolized by the tissues so that the total pressure of gas at the venous end of the capillaries is less than 100 mm Hg while the gas mixture in the cysts (principally nitrogen), remains at or above atmospheric pressure. The pressure gradient which determines the rate of removal of gases from the cyst is thus considerably reduced. A similar approach has been used to relieve pain and symptoms with postoperative abdominal distention and in pneumothorax.

Although the cause of pneumatosis intestinalis is not always apparent, mechanical intestinal problems with increased pressure, pulmonary disease, or intestinal infections probably all contribute, although in any one case one etiologic factor is probably dominant and may be the only responsible factor. Regardless of the etiology careful evaluation of x-ray film with establishment of a diagnosis of pneumatosis coli or pneumatosis intestinalis makes possible nonsurgical treatment of this condition cheaply and simply with oxygen. This is particularly important as many of these patients are relatively poor surgical risks.





Figures 2 and 3—Microscopic studies revealed cysts beneath the serosa, in the musculature, but predominantly in the submucosa.

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ABSTRACT WISCONSIN AUTHORS

Diphenylhydantoin effects on thyroid function tests

ROBERT H CAPLAN, MD; ROBERT MORDON, BS; KAREN KRISTOFF, BS; and GARY WICKUS, PHD, Gundersen Clinic Ltd and LaCrosse Lutheran Hospital, LaCrosse, Wis: *Ann Neurol* 1:603-604 (June) 1977

We measured serum as thyroxine iodine (T_4I), triiodothyronine resin uptake (T_3U), free thyroxine index (FTI), and free thyroxine equivalent (FTE) in 31 euthyroid patients treated with diphenylhydantoin (DPH) and in 105 euthyroid control subjects. The T_4I was reduced by 30%, the FTI and FTE were reduced by 25%, and the T_3U was slightly increased in the DPH-treated patients. We conclude that these tests are not accurate estimates of thyroid function in patients treated with DPH if the usual range is utilized for interpretation. ■

Amniocentesis under ultrasound guidance with aspiration transducer

Patricio Barriga, MD; Gloria Sarto, MD; and Jacquelyn Cassidy, RT; Madison, Wisconsin

GENETIC AMNIOCENTESIS is a well known and accepted procedure and is widely performed. The use of diagnostic ultrasound B-scanning placental localization before amniocentesis has been emphasized by many authors.[1-6] The aspiration transducer is extensively used for monitoring renal cyst aspiration for fluid studies and for injection of contrast medium prior to x-ray films. It appears logical that the aspiration transducer also should be utilized for obtaining amniotic fluid during amniocentesis; however, even though this is done in a few centers, not many reports of its usefulness have appeared in the literature.

We have been doing amniocentesis with previous ultrasound scans for two years, and for the last year and a half under guidance with the aspiration transducer. During this time, we have performed 55 amniocenteses that have been successful in 47 cases (85%). The remaining eight patients (15%) were repeated at a later date. Five were successful at the second attempt and two at the third. The other patient chose not to have the procedure repeated.

We perform the amniocentesis after compound ultrasound scans of the abdomen in the longitudinal and transverse directions, and after having localized the position of the placenta and the fetal parts. Once

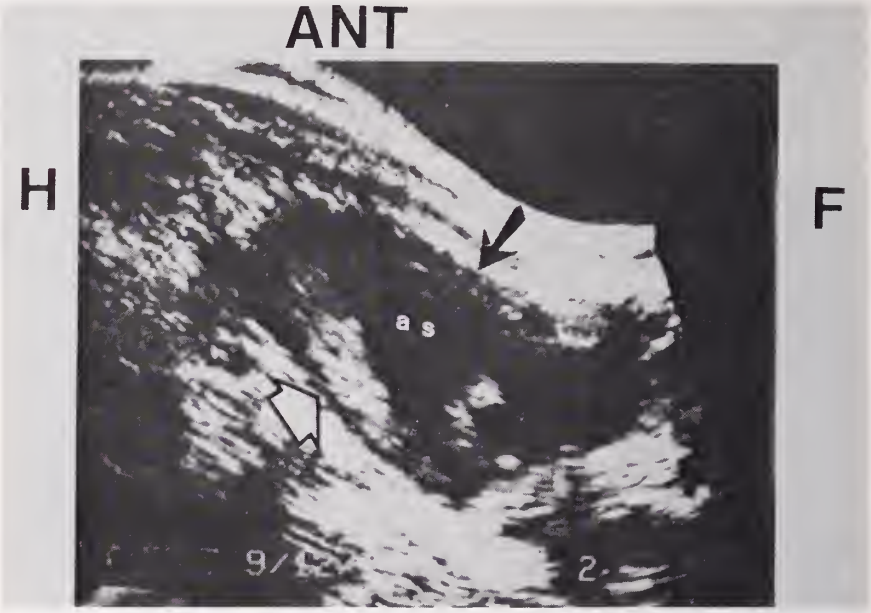

Figure 1—Midline longitudinal B-scan of a 14-week-old pregnancy with posterior and fundal placenta (arrowhead). Selected place for amniocentesis (arrow). Fetal head not shown in this scan.

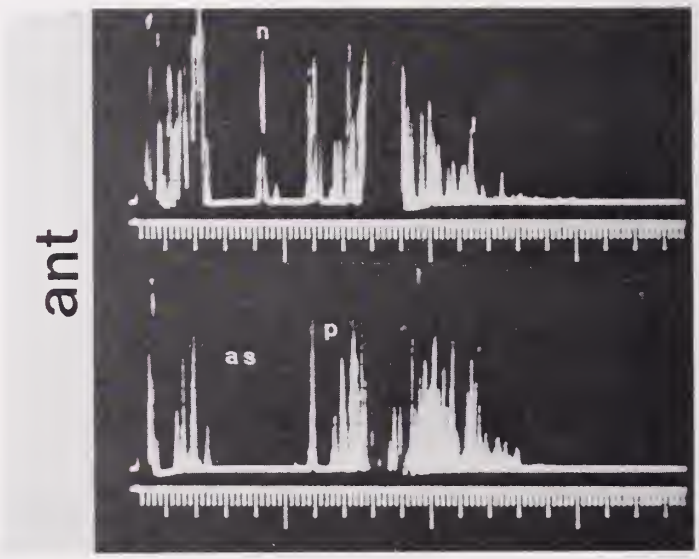

Figure 2—A-mode presentation at site of amniocentesis. Lower half shows echo-free space that represents the amniotic sac (as). The posterior placenta also can be identified (p). Upper half shows the spike from the needle (n) in the middle of the amniotic space at 4.6 cm from the abdominal wall.

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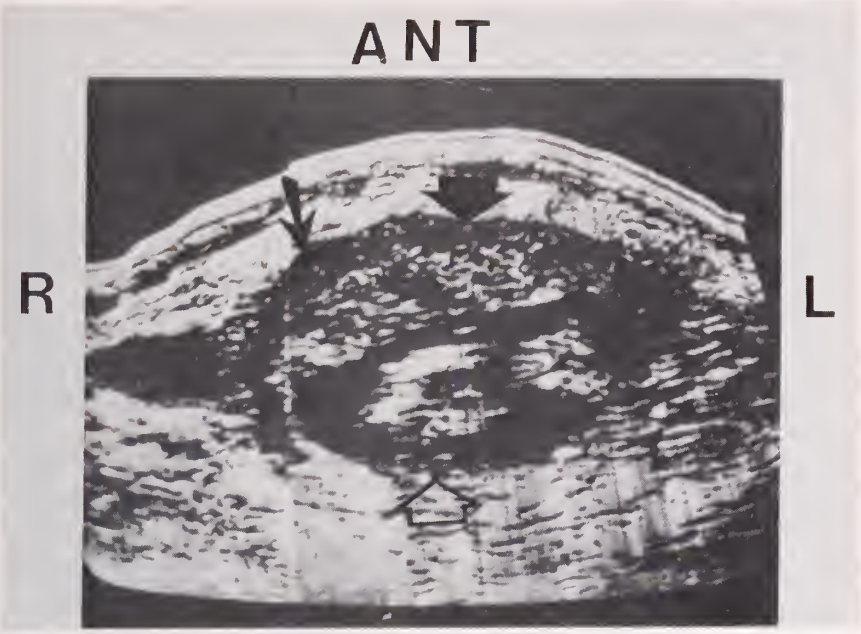

Figure 3—Transverse scan showing anterior placenta (black arrowhead), fetal parts (arrowhead), and place selected for amniocentesis (arrow).

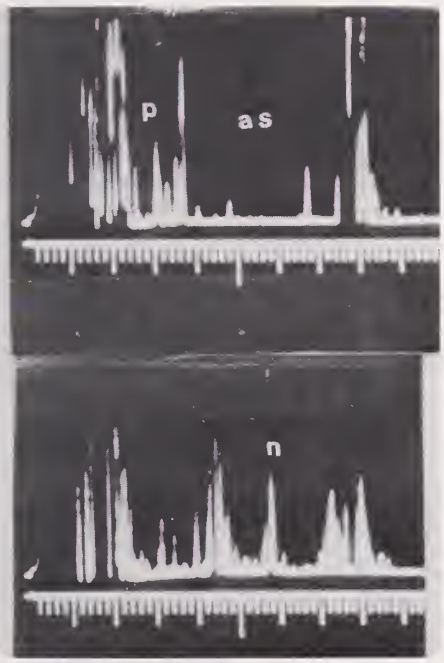

Figure 4—Same patient: A-mode display at the level of the arrow in Figure 3. It is possible to identify the anterior placenta (p), amniotic space (as), and the spike from the needle (n) in the lower picture.

all these structures have been identified, a suitable amniotic fluid-filled space is marked over the patient's skin. Under sterile technique, this space is again checked with aspiration transducer in the A-modality. This not only allows easy identification of the amniotic space but also permits exact measuring of the distance from the skin to the amniotic sac. It also gives the angle of punction when it is necessary. Because of fetal movements, this is a much safer way to perform this procedure, since one sees the echo-free amniotic space and the needle insertion is guided by the aspiration transducer. An additional advantage of amniocentesis with aspiration transducer is that in many instances the spike from the needle can be visualized and the exact position of the needle can be determined. In our series the needle has been seen in 50% of the cases. It is possible that at higher sensitivity level of the equipment, and with a slight movement of the aspiration transducer so that better contact of the needle is obtained as it goes through a central hole, a higher incidence of visualization of the needle spike can be achieved. When amniotic fluid is being obtained, we are not too concerned if the needle spike is not visualized.

By using the help of ultrasound in the compound scan modality as well as aspiration transducer, we feel that we have increased the safety of the procedure. Bloody taps have been almost nonexistent in spite of the fact that if the placenta is located anteriorly, we do not hesitate to insert the needle transplacentally.

It should be noted that we now are doing amniocentesis at about the sixteenth week of pregnancy. This makes the procedure simpler, there is more amniotic fluid present, and fetal parts can be well identified and avoided. Since we have been doing this, the rate of failure has been much lower. We also feel that we still have enough time for cell culture and lab studies of the amniotic fluid before the 20-week limit accepted by many for an abortion. As a rule we do not make more than three attempts of obtaining amniotic fluid at one sitting. We prefer to call the patient back at a later date.

The one serious complication in our series of cases was an abortion.

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Management of patients with severe coronary disease during noncardiac surgery

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RECENT ADVANCES in the treatment of coronary artery disease (CAD) have enhanced our awareness of CAD in the general surgical patient. However, a dilemma may result when significant CAD is detected in a patient with a pressing indication for major noncardiac surgery. The availability of the coronary bypass operation often makes one reluctant to proceed with the noncardiac operation unless preliminary or simultaneous coronary bypass is carried out.

Such a dilemma was presented to us by a patient with signs of carcinoma of the lung and severe coronary disease. Thoracotomy and lung resection appeared indicated for optimum therapy of her lung cancer, but her extensive CAD made such a major operation unacceptably hazardous. On the other hand, preliminary coronary bypass surgery appeared unwarranted in a patient with a malignant (and possibly incurable) lesion. The problem was resolved by using the intra-aortic balloon pump to support her heart while an exploratory thoracotomy was carried out. The principle applied in this case may have much wider applicability and the relevant considerations are therefore presented in detail.

Case report

A 65-year-old female had a 1-cm diameter coin lesion in the right lower lobe on a routine chest x-ray film. The lesion doubled in size over a six-month period, and she was referred for evaluation. Her history revealed a 10-year period of exertional angina, and three episodes of spontaneous ventricular fibrillation 15 months earlier, from which she was resuscitated by paramedics with only minimal neurological injury. She refused coronary angiography at that time, and in the intervening months she was treated medically for premature ventricular contractions, exertional angina, congestive heart failure, and diabetes.

On admission to the Milwaukee County Medical Complex she was in mild congestive heart failure, electrocardiographic studies were suggestive of an old anteroseptal myocardial infarction, and a stress test was positive. The patient now agreed to coronary angiography, which revealed complete occlusion of the dominant right coronary artery, severe stenosis of the anterior descending, and diffuse disease of a small circumflex coronary artery. Tuberculin skin and sputum tests were negative. It was believed she had potentially curable carcinoma of the lung; but the risk of anesthesia, thoracotomy, and pulmonary resection seemed unacceptably high. On the other hand, coronary bypass surgery seemed unwarranted in a patient with malignant disease. Radiation therapy alone was considered inadvisable, as a tissue diagnosis was unobtainable by conventional means and the extent of the disease was unknown. Mediastinoscopy to determine operability would have required general anesthesia.

It was therefore concluded that the best management would consist of supporting the myocardium by intra-aortic balloon pumping (IABP) during exploratory thoracotomy. Accordingly, an IABP was inserted transfemorally under local anesthesia and a right thoracotomy was performed. A surprisingly widespread, poorly differentiated squamous carcinoma with hilar and subcarinal lymph node metastases was found; resection was not carried out.

Evidence of the patient's precariousness was provided by an episode of transient hypotension during preparation of the groin for IABP insertion under local anesthesia. With IABP she subsequently was quite stable hemodynamically throughout thoracotomy. The IABP was removed in the Intensive Care Unit 24 hours postoperatively. Her course thereafter was characterized by repeated episodes of respiratory insufficiency requiring three intervals of mechanical ventilation. She was extubated for the fourth time eight days postoperatively and required tube feedings and hyperalimentation because of repeated aspiration of oral fluids. As a result, her pulmonary status gradually deteriorated and she developed staphylococcal pneumonia. This infection complicated management of her diabetes and vice versa. She developed a hyperosmolar state and renal insufficiency, both of which responded to appropriate medical therapy. Nonetheless, her pulmonary status deteriorated progressively, she became obtunded, and died of a respiratory arrest three weeks postoperatively. Cardiac output was clinically satisfactory throughout this period; and had cardiac performance compromised her recovery directly, the IABP could have been reinserted.

Discussion

Intra-aortic balloon pumping reduces myocardial oxygen demands by reducing left ventricular afterload and improves tissue perfusion by increasing cardiac output.[1] Its effect on coronary perfusion is variable, and depends on a balance between decreased left ventricular work and oxygen demands, and increased aortic diastolic pressure (oxygen supply).[1] Laboratory and clinical studies indicate that IABP can preserve and protect jeopardized myocardium in patients with acute myocardial ischemia.[2,3] It should do likewise in patients with

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recognized coronary artery disease whose myocardial perfusion must be jeopardized temporarily by anesthesia and major noncardiac surgery. IABP can be instituted readily under local anesthesia, systemic anticoagulation is not obligatory, and major complications are uncommon.[3]

When patients with known coronary disease must undergo potentially hazardous operations, the major cause of operative risk for such patients is usually their cardiac condition, rather than the noncardiac disease that prompts operation. It seems likely that IABP will be used with greater frequency in such patients as its worth becomes more widely appreciated. However, the IABP is an expensive device that requires constant supervision by trained nursing and technical personnel. Optimum management of certain patients will require harmonious collaboration between hospitals without balloon pumps and cardiac surgery centers.

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ABSTRACT WISCONSIN AUTHORS

Acute Retrolental Fibroplasia

James D Kingham, MD, Milwaukee, Wis: *Arch Ophthalmol* 95:39-47 (Jan) 1977

With the advancement of the science of neonatal perinatology, there has been an increase in the number of surviving infants of low birth weight. In the period from Dec 1, 1971 to Apr 30, 1976 (53 months) one observer, JDK performed ophthalmic examinations on 384 infants and identified 68 cases of retinopathy of prematurity.

Normal infants had no posterior dilation or tortuosity of retinal vessels. The arteries and veins were identifiable as such out to the limits of their resolution and the terminal vessels branched in an orderly manner.

Grade I RLF was that stage of retinopathy which had abnormal terminal arborization of vessels, abrupt vascular/avascular junction, and usually no posterior dilation or tortuosity of vessels. Thirty-three of the 68 affected infants had Grade I RLF on initial exam.

Grade II RLF was that stage of retinopathy which had abnormal terminal arborization, and equatorially oriented intraretinal line, and usually no posterior dilation or tortuosity. Twenty-five of the 68 affected infants presented with Grade II RLF.

Resolution with sequela was the rule in Grade I and Grade II RLF and it occurred by 11 to 16 weeks of age.

Grade III RLF was characterized by extraretinal extension of vascular elements into the vitreous. These were present either as ascending capillary networks or as sinusoids. Eight of the 68 affected infants presented with Grade III RLF. Resolution was less predictable in those infants with Grade III RLF and usually did not occur until 20 to 30 weeks of age.

Grade IV RLF was that stage of retinopathy in which a portion of the peripheral retina was detached by traction. Two infants presented with Grade IV RLF.

Grade V RLF was present when the entire retina was detached. No infant presented with Grade V RLF but some cases progressed to that stage.

In those cases of Grade IV and Grade V RLF which eventually resolved there was also some sequela including preretinal membranes, diffuse pigmentary changes, temporal fibrovascular mass, temporal dragging of vessels, ectopic maculae, and retrolental cicatrix.

Those infants affected most were not only small with birth weight less than 1600 grams but had systemic illness as well including respiratory distress syndrome, multiple apnea, hypothermia, pneumothorax, patent ductus arteriosis, congestive heart failure.

Ophthalmic monitoring of vessel caliber is neither feasible nor efficacious. Examination is deferred until the infant weighs about 1500 grams and this is done with a maximally dilated pupil, lid speculum, indirect ophthalmoscopy, and scleral depression. ■

Endoscopic electrosurgical papillotomy and manometry in biliary tract disease

Joseph E Geenen, MD; Walter J Hogan, MD; Robert D Shaffer, MD; Edward T Stewart, MD; Wylie J Dodds, MD; and Ronald C Arndorfer, Medical College of Wisconsin, Milwaukee, Wis: *JAMA* 237:2075-2078 (May 9) 1977

Endoscopic papillotomy was performed in 13 patients after cholecystectomy for retained or recurrent common bile duct calculi (11 patients) and a clinical picture suggesting papillary stenosis (two patients). Following endoscopic papillotomy, 10 of the 11 patients spontaneously passed common bile duct (CBD) stones verified on repeated endoscopic retrograde cholangiopancreatography (ERCP) study. One patient failed to pass a large CBD calculus; one patient experienced cholangitis three months after an inadequate papillotomy and required operative intervention. Endoscopic papillotomy substantially decreased the pressure gradient existing between the CBD and the duodenum in all five patients studied with ERCP manometry. Endoscopic papillotomy is a relatively safe and effective procedure for post-cholecystectomy patients with retained or recurrent CBD stones. The majority of CBD stones will pass spontaneously if the papillotomy is adequate. The role of endoscopic papillotomy in papillary stenosis and other sphincter of Oddi disorders require further evaluation including manometry of the sphincter of Oddi. ■

L/S ratios in twin pregnancy

Ronald W Olson, MD, Madison, Wisconsin

THERE HAS BEEN some controversy regarding the assessment of pulmonary maturity in twin gestations. The present article discusses the various problems involved and reflects the approach taken at the Wisconsin Perinatal Center in Madison.

SINCE THE description by Gluck[1] in 1971 of the value of amniotic fluid phospholipid measurements in the prediction of respiratory distress of the newborn, the determination of the lecithin sphingomyelin (L/S) ratio has become the most generally accepted method of assessing the risk of morbidity and mortality in the infant threatened with premature delivery.

Other parameters of fetal maturity, such as radiologic demonstration of fetal ossification centers, have failed the test of time and have been largely discarded. More recent attempts to determine fetal maturity have focused on the biochemistry or cytology of amniotic fluid in the hope that these parameters might accurately reflect the increasing physiologic maturity of the fetus.

Amniotic fluid bilirubin, creatinine, fetal fat cells and an array of other constituents have all had their advocates. Some authors have attempted to utilize combinations of several such tests.[2] Singly or in combination they have proved useful in establishing gestational maturity, but such tests tend to give all or nothing results and are not optimal in predicting the outcome for infants of less than 37 weeks gestation. Pulmonary maturity is the main determinant of fetal outcome at less than 37 weeks and the lecithin-sphingomyelin ratio remains the most accurate means of measuring biochemical lung maturation.

Many potential errors in L/S ratio determination have been recognized. Blood or meconium in amniotic fluid can adversely affect values.[3] Results are no more reliable than the laboratory determining them. The test is best done in the well-equipped laboratory with sufficient volume and adequate internal controls.

Even given optimal conditions, a special problem exists in the case of twin pregnancy. The risk of premature delivery is enhanced and the attendant risks may not be the same for both infants. Spellacy[4] recently reported on 12 sets of twins where transabdominal amniocentesis was performed on each amniotic sac separately. The L/S ratios were said to show "no significant difference." The authors then concluded that "only one amniotic sac needs to be punctured, as the L/S ratio will not be different in the second sac." The gestational ages of the pregnancies were not specified, however, and inspection of the L/S ratios reported reveals that in the 28 infants only 7 had L/S ratios less than 2.0 (mature). Presumably the majority of pregnancies were mature. Obviously if the L/S ratios are both "mature," little concern need be had if they differ. Conversely if one value is borderline (say 2.0), a minor variation (say 0.5 less in the other twin), would suggest an unacceptable risk of respiratory distress in the less mature twin.

We recently delivered a twin pregnancy in a patient at 36.5 weeks with reliable dates. The L/S ratios were 7.7 and 4.5 (our level of "maturity" is 3.5). This difference was significant but unimportant since both demonstrated adequate lung maturation. Had the more mature twin demonstrated a ratio of 3.5 and the same relative difference existed, the second twin might have had a ratio of 2.0, a value carrying a risk of respiratory distress of 27% and a risk of death due to respiratory distress of 13% in our experience.

Pritchard[5] notes a quintuplet pregnancy where the smallest infant, weighing 860 gm, had an L/S ratio of over 5 and experienced no respiratory distress. The largest sibling, weighing 1530 gm, had an L/S ratio of less than 2.0 and was severely affected. Gluck and Kulovick[6] also have warned of the marked differences in L/S ratios and pulmonary function in twins. Obladen and Gluck[7] evaluated tracheal aspirates from eight pairs of twins all delivered at less than 37 weeks. They demonstrated highly

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significant differences between twins in L/S ratios as well as in phosphatidylinositol / phosphotidylserine ratios and in the presence or absence of phosphatidyglycerol.

Pulmonary maturation is as likely dependant upon factors inherent in the fetus as upon factors in his environment. Therefore, there is no more assurance that pulmonary maturation proceeds at the same rate or occurs at the same time for twins than for siblings resulting from separate pregnancies. If maturity assessment is needed in twin pregnancy, it would seem advisable that each infant be evaluated separately and reliance not placed on the L/S determination of one twin as predicative of the outcome of the other. Amniotic fluid from each should be sampled.

While it may not always be possible to perform amniocentesis on both sacs, the attempt should be made. A technique has been described by Young.[8] Sonography is used to localize the placentas and confirm the position of the twins. Amniocentesis is then performed at a site selected to avoid the placenta and enter the sac of one twin. When fluid has been withdrawn, 35 ml of Reno-M-30® and one ampule of Evans Blue dye are injected and the needle removed.

A flat plate of the abdomen is then taken to ascertain whether a single sac or separate sacs are present. If only one sac is visualized, no further amniocentesis is attempted. If a second sac is suggested, a second puncture site is selected over the second fetus and away from the first sac. Clear fluid on the second tap indicates the second sac has been entered. Blue fluid suggests a common sac or that the sac of the first twin has been re-entered. Neither the Renografin nor the dye should interfere with later serial L/S determinations if these are needed.

In utilizing this technique in the Southcentral Region Perinatal Center at Madison General Hospital we have frequently found it possible to localize the second sac with careful ultrasound scanning, avoiding the need for x-ray. Young utilized this technique in the early midtrimester with success. In those pregnancies more advanced to 32-36 weeks, the success rate should be even greater.

While lung maturity of each twin may be reliably predicted by evaluation of the L/S ratio of only one when the pregnancy has progressed beyond 37 weeks, this may be a dangerous assumption if the gestational age is uncertain or if it is known to be less than 37 weeks. Adequate evidence has been presented to suggest that twins do not develop lung maturation at the same rate or the same time.

The only safe recourse is to perform amniocentesis and evaluate L/S ratios on each twin whenever this is possible. A technique has been described to assist in this attempt.

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ABSTRACT WISCONSIN AUTHORS

The Blalock-Taussig operation: the procedure of choice in the hypoxic infant with tetralogy of Fallot

Paramjeet S Chopra, MD; Jay M Levy, MD; Guillermo C Dacumos Jr, MD; Herbert A Berkoff, MD; Louise L Loring, and Donald R Kahn, MD, University of Wisconsin Hospitals, Madison, Wis:

Ann Thorac Surg 22: 235-304 (Sept) 1976

From 1971 to 1975, 17 consecutive patients aged 1 day to 4 years underwent Blalock-Taussig shunts for severe tetralogy of Fallot. Three infants were under 6 weeks of age and 7 (41%) under 1 year. There were no hospital deaths. Modification of the shunt technique adapts it to any size infant. The subclavian artery is divided at its major branches and the end spatulated to enlarge it. The artery is occluded while the shunt is constructed.

No intraoperative complications were encountered; all patients have a shunt murmur with no early or late closure. No child has had heart failure or hypoxic spells. Flows measured at operation equaled one-quarter to one-half of the child's normal cardiac output. Ligation of the shunt at subsequent repair is uncomplicated. One child died three years later at correction from causes unrelated to the shunt.

With appropriate modifications in technique, the Blalock-Taussig shunt is the operation of choice, at any age, for palliation of severe tetralogy of Fallot. ■

A lower extremity elevator for venous and lymphatic stasis

VICTOR M BERNHARD, MD, Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 112:663 (May) 1977

Elevation of the lower extremities above the level of the heart is routinely recommended to patients with venous and lymphatic stasis problems. However, this advice is generally ignored because of the absence of a convenient method for achieving comfortable leg elevation. A foam rubber wedge which is readily available* was designed to meet physiologic requirements and achieve patient acceptance. It is three feet long, fifteen inches high, and two feet wide. It is covered with a removable Dacron slipcover for easy laundering, fits any size bed, and is not objectionable to the patient's sleeping partner. The upper surface has a fifteen degree break to permit mild knee flexion to avoid popliteal venous compression.

A model depicting the elevation of legs using a foam rubber wedge.

*Jobst, Inc, Toledo, Ohio. ■

Patterns of Blood Pressure in Milwaukee

HAROLD D ITSKOVITZ, MD; MAHENDRA S KOCHAR, MD; ALFRED J ANDERSON, MS; and ALFRED A RIMM, PhD, Medical College of Wisconsin, Milwaukee, Wis: *JAMA* 238: 864-868 (Aug 22) 1977

Blood pressure measurements were obtained among 92,074 persons in Milwaukee between 1974 and 1976 by the Milwaukee Blood Pressure Program. Systolic hypertension was more prevalent in young white men than blacks below 25 years of age, was more common in middle-aged blacks than whites, and was equally prevalent among all persons past 65 years. Diastolic hypertension was more prevalent in blacks than whites of all ages. Whereas the prevalence of systolic hypertension in the population increased with age and was present in a majority or near majority of persons past 65 years, the prevalence of diastolic hypertension rose until the sixth decade, after which it declined. Hypertension was primarily of a diastolic variety in young blacks, whereas systolic hypertension was a prominent feature in young whites. ■

Reconstitution of B and T lymphocyte function in severe combined immunodeficiency disease after transplantation with thymic epithelium

RICHARD HONG, MD; MATURAM SANTOSHAM, MD; HERMAN SCHULTE-WISSERMANN, MD; SHELDON HOROWITZ, MD; SUSAN H HSU, PhD; and JERRY WINKELSTEIN, MD, University of Wisconsin Hospitals, Madison, Wis: *Lancet* 2:1270 (Dec) 1976.

A 10-month-old child with severe combined immunodeficiency disease (SCID) received a transplant of cultured thymic epithelium. Four weeks later, immunoglobulins were detected and acquisition of positive tests of T cell function was noted.

There was reversal of wasting, cessation of malabsorption, and development of a normal weight gain pattern. The child was discharged to her home environment and has been free of infections for seven months since the transplant. At the time of this writing, her immunoglobulin levels are normal for her age. She responds to newly acquired antigens and viral infections with antibody formation. Surprisingly, her T cell status remains impaired (about 25% of normal) but appears to be adequate for her needs at the present time. No complications of the procedure have been observed.

This experience introduces a new modality of treatment which should benefit many forms of immunodeficiency. ■

Coronary artery occlusion and alcohol intake

JJ BARBORIAK, ScD; AA RIMM, PhD; AJ ANDERSON, MS; M SCHMIDHOFFER, MD; and FE TRISTANI, MD, VA Center, Wood, Wis: *Brit Heart J* 39: 289-293 (Mar) 1977

The possible association between alcohol intake, blood lipid levels and extent of coronary artery occlusion was studied in 909 male patients who had coronary arteriography. The patients who consumed more than an equivalent of 360 ml (12 oz) of ethanol per week were younger, had higher plasma triglyceride levels and less coronary artery occlusion than the abstainers or patients consuming less than 180 ml (6 oz) of ethanol. These findings suggest that: (1) An excessive alcohol intake may produce symptoms of coronary artery disease not commensurate with the extent of coronary artery occlusion. (2) The alcohol-induced elevation of plasma triglycerides may not be associated with a reduction of coronary artery lumen. ■

Herniated lumbar disc with leg paralysis associated with JOGGING – case report

Gary N Guten, MD and Donald J Harvey, MD
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JOGGING, which is running at a slow leisurely pace, slower than an eight-minute mile, can be associated with specific medical problems. The purpose of this report is to present the first published case of a herniated lumbar disc with leg paralysis associated with jogging.

The syndrome of low back pain in joggers has been rarely reported in the literature. It is my clinical experience that a jogger, particularly in the middle age, can have significant low back problems.

Review of literature

Although running and jogging have been universal sports, very little has appeared in the orthopedic literature on running in general and jogging in particular.[1,2] A few investigators have commented on back problems in runners; however, I have been unable to locate any reported cases of severe disc pathology specifically associated with jogging.

Brubaker and James[3] reported a series of 4,850 injuries in runners, yet only 2 patients were reported with low back syndrome. Glick and Katch[4] reported 120 joggers with medical problems and found 11 with low back pain, but no disc symptoms were reported. Corrigan,[5] from Australia, presented all of the complications of joggers ranging from jogger's foot to jogger's knee to jogger's hip, but no reference was made to back pain in joggers. In a review of spine injuries and athletics by Liedholt,[6] no particular reference is made to spine pathology in runners.

Biomechanics of running and low back strain

Human locomotion has been well defined for walking gait patterns by Murray,[7] in detailed kinesiology studies. The classical studies on running by Slocum, James and Brubaker,[8-11] define the postural changes associated with running. They noted that lumbar lordosis can develop with extension of the leg, particularly with long strides. Chronic lordosis can develop due to tight lumbar fascia and reduced lumbar mobility with aging. They felt that impingement and overriding of the facets would develop as a cause of low back pain in running. However, specific disc pathology has never been reported in a jogger.

Case report

This 38-year-old white male presented with a chief complaint of acute leg paralysis progressing over a five-day period while jogging regularly three miles a day. Running was done in "tennis shoes" on paved concrete streets and sidewalks. Table 1 shows details of the history. He first developed low back stiffness and back pain which progressed to painful paresthesias and sensory loss in a typical sciatic fashion. After two more days of jogging, he then developed progressive "muscle soreness" which progressed to rapid paralysis of his foot.

The patient's history revealed he had been jogging for 10 years. During that time his weight reduced from 218 lb to 158 lb. General health had been excellent except for a few episodes of mild low back stiffness not requiring medical attention.

Table 1—Jogging history: 1972

Day	*Back Pain*	*Leg Numbness*	*Leg Weakness*
1	Stiff	0	0
2	+ + + +	+	0
3	+ +	+ + +	+
4	+	+ +	+ + +
5	±	+	+ + + + (Flaccid)
6	Myelogram		
7	Surgery		

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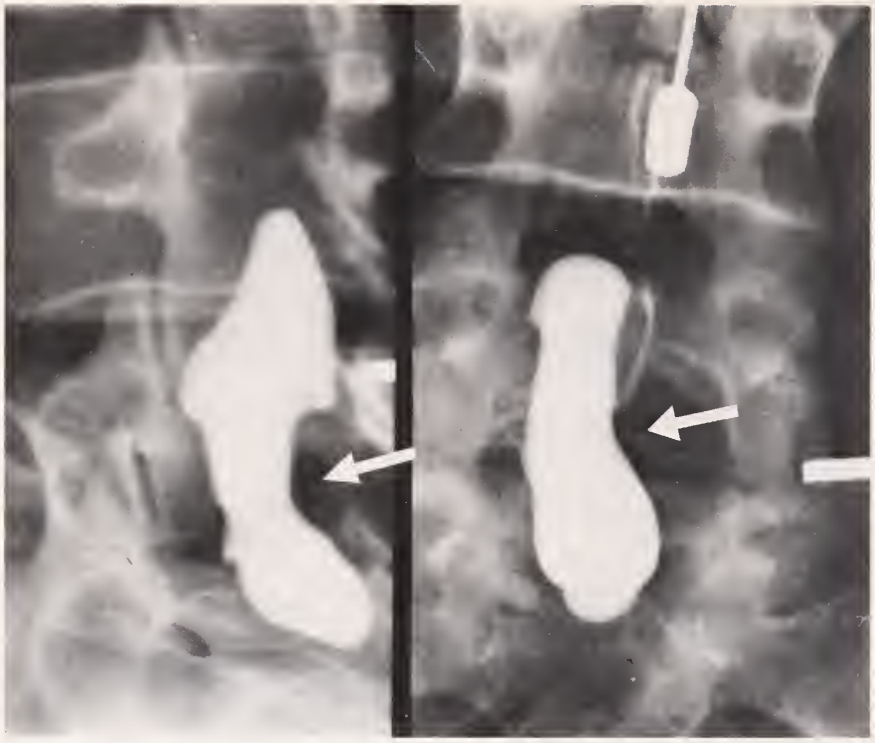

Figure 1—Anteroposterior and oblique views of the lumbar myelogram with large extra dural defect at L5-S1 (at arrow).

On physical examination the patient walked with a definite limp, listing to the left. He was unable to dorsiflex the left foot while walking on his heels. Back mobility was reduced with pain aggravated by hyperextension and left lateral bending. The left sciatic notch was very tender. Straight leg raising was definitely positive at 60 degrees on the left with crossed referred pain by right straight leg raising.

A neurological examination showed the left hip abductors to be slightly weak. The left dorsiflexors of the foot were flail. The peroneal muscles were moderately weak. Sensory loss extended on the lateral aspect of the foot and anterior shin. The ankle reflex was absent.

Initial x-ray films showed minimal narrowing of L5-S1 interspace.

An emergency myelogram was done (Fig 1). A large extradural defect was noted at L5-S1 extending to L4-L5.

A laminectomy was done at L5-S1. A massive extruded disc was found at L5-S1 extending proximally, involving both L5 and S1 nerve roots.

During the postoperative course, there was rapid relief of the patient's pain and paresthesias. The foot remained flail for about three to six months. He was fitted with a fixed ankle brace which he wore for approximately three months. At six weeks, he began light running and progressed to full jogging at three months. Three years following the operation, he was still running 20 miles a week. Except for occasional muscle cramps in his calf region, he was asymptomatic. Occasional strains of his ankle while running developed due to slight residual peroneal weakness.

Jogging postoperatively

At six weeks post laminectomy, this patient had returned to running and over a three-year period has returned to a very heavy jogging schedule of three miles a day. Initially he was advised not to run, but the patient felt that his running was not deleterious to his back and leg.

Summary

Even though it is my clinical experience that joggers, particularly in the middle age, have significant low back complaints, the review of the medical literature has failed to show statistics that runners have low back problems.

The biomechanical studies of running have shown that lumbar lordosis can develop and can be associated with chronic low back syndrome and pain.

A case was presented in which the patient developed a severe herniated disc with leg paralysis while jogging.

In the postoperative period, this patient was able to rehabilitate himself successfully and return to an active jogging program post laminectomy.

Joggers and runners should be aware of the chronic strain that can be placed on their lumbar spine. They should take medical measures to reduce this strain by:

(1) Doing William's exercise to maintain lumbar mobility.
(2) Running on soft surfaces and wearing proper jogging shoes.
(3) Reducing their stride length which will reduce the strain on the lumbar area.

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Radiotherapy of early stage carcinoma of the larynx

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• The experience in the treatment of early stage squamous cell carcinoma of the larynx at the University of Wisconsin Radiotherapy Center during the megavoltage era (1960-1975) is presented. Sixty-three patients have been treated. Eight patients had recurrences after radiotherapy and five were subsequently salvaged with surgery. Treatment was without significant morbidity or complications.

RADIOTHERAPY IS highly effective as the primary treatment in squamous cell carcinoma of the larynx. Megavoltage treatment has provided an effective therapy which causes little morbidity and allows preservation of the patient's voice. The purpose of this paper is to report the results of treatment with primary radiotherapy for early stage carcinoma of the larynx at the University of Wisconsin Radiotherapy Center during the megavoltage era.

Materials and methods

During the period of January 1, 1960 to July 1, 1975, 211 patients with the diagnosis of squamous cell carcinoma of the larynx were treated at the University of Wisconsin Radiotherapy Center. Sixty-three patients had early stage disease; 49 had stage I disease, and 14 had stage II disease. The remainder of patients treated had more advanced disease or were treated after they had failed surgical therapy. Because the American Joint Committee (AJC) staging system was changed in 1972, all cases were reviewed and reclassified according to that staging system (Table 1).

Three patients with stage I disease and five patients stage II disease had supraglottic cancers. The remainder had glottic cancers. There were no subglottic primaries.

The mean age of the patients treated with stages I and II disease was 63 years. Eight of the patients were women and the remainder were men. All had a significant history of smoking. Pretreatment evaluation included a direct laryngoscopy and biopsy in all cases. Laryngeal tomograms were performed in nearly all cases, and laryngograms were often done. Pathology showed squamous cell carcinoma, either well differentiated or moderately well differentiated, in all cases.

During the first few years of this review, therapy was done with a 1 MeV resonance transformer generator and thereafter with either CO^{60} or 4 MeV linear accelerator. Patients were treated with opposed lateral fields. In the earlier years a single field was treated daily, alternating the fields each day, but thereafter each field was treated daily. The doses in the earlier years also tended to be lower. Stage I cancers were treated to a dose of 6000 rad at 200 rad per fraction, five days per week; and stage II cancers were treated to approximately 6500 rad. The doses have gradually increased to the current levels of approximately 6500-6600 rad for stage I disease with fractions of 200-220 rad. The fields for stage I glottic cancer are generally 5 to 6 cm square and encompass the larynx. It is not necessary to treat the cervical lymph nodes electively since the true vocal cords do not have lymphatics. In stage II disease doses of 6800 to 7000 rad are now used. Generally fields 7 x 10-12 cm are opposed to encompass the larynx primary and the cervical nodes at risk to a dose of 5000 rad. The primary tumor is then boosted with smaller 5-6 cm fields to 6800 to 7000 rad. The stage I supraglottic cancers are treated with this technique also since the lymphatic supply in this area is significant, making cervical nodes at risk for metastases.

Table 1

Staging of laryngeal cancer—American Joint Committee 1972

Stage I—T1/NO, N1a, N2a/MO

Stage II—T2/NO, N1a, N2a/MO

T1S—carcinoma in situ
T1 —tumor limited to one anatomical region within the larynx with normal mobility
T1a—tumor involving more than one site
T2 —tumor extending beyond one anatomical region but confined to the larynx without fixation
T3 —tumor as in T1 or T2 with fixation of larynx
T4 —tumor extending beyond larynx
N0 —cervical lymph nodes not palpable
N1 —palpable, not fixed, homolateral, lymph nodes
N1a—metastases not suspected
N1b—metastases suspected
N2 —palpable bilateral, contralateral, or midline nodes not fixed
N2a—metastases not suspected
N2b—metastases suspected
N3 —fixed cervical nodes, metastases suspected
M0 —no distant metastases
M1 —distant metastases

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Results

The results of treatment are presented in Table 2 and a detailed analysis of patients who failed therapy is summarized in Table 3. In stage I, only three patients have developed a recurrence following definitive radiotherapy. All three had a laryngectomy in an attempt to control the recurrence. Two of these patients ultimately died of larynx cancer; the third was free of disease until death at 43 months from a primary bronchogenic cancer.

In stage II, five patients have failed after radiotherapy. In four the primary was supraglottic, and in one it was glottic. Four of the patients were treated with a laryngectomy (plus radical neck dissection if appropriate) in an attempt to control the recurrence. One patient has died from laryngeal cancer, and another is alive with disease at 16 months. Two patients are currently alive without disease at 45 and 189 months respectively. The fifth patient died of a myocardial infarction at 31 months and had no evidence of cancer at death. In both stages I and II, failures occurred during the initial two years after therapy.

There were no major complications from treatment. No instances of laryngeal cartilage necrosis were recorded, and no severe impairment of laryngeal function occurred. In all cases, the voice after therapy was described as being as good or better than the pretreatment voice.

Table 2—Survival of patients with early stage carcinoma of larynx treated with radiation therapy at University of Wisconsin Hospitals 1960-1975

Survival (years)	*Number at risk*	*Number surviving*	*Intercurrent deaths, no evidence larynx cancer*	*Died of larynx cancer*
			STAGE I	
1-2	49	45	4	0
2-3	46	38	8	2
3-4	39	27	10	2
4-5	33	23	8	2
5	30	20	8	2
			STAGE II	
1-2	14	14	0	0
2-3	12	10	1	1
3-4	12	10	1	1
4-5	10	9	0	1
5	10	7	2	1

Table 3—Failure of treatment in early stage carcinoma of the larynx 1960-1975

Patient	*Age*	*Primary site Stage*	*Treatment dose/Fractions elapsed time*	*Time and possible reason for failure*	*Retreatment*	*Follow-up status*
F. W.	71	Anterior left cord and commissure T, N, M0.	6000 r/30 fractions 40 days.	Local failure at 8 months. Relatively low dose.	Laryngectomy.	Recurred in tracheal stoma and ultimately died of disease at 31 months.
J. M.	48	Right cord T1, N0, M0.	6500 r/30 fractions 39 days.	Local failure—19 months. Review of old x-rays shows subglottic extension.	Laryngectomy.	Died of metastatic disease at 26 months.
E. S.	67	Left cord T1, N0, M0	6000 r/30 fractions 51 days.	Local failure—9 months. Relatively low dose.	Laryngectomy.	Died of bronchogenic carcinoma at 43 months. Free of larynx cancer.
D. G.	43	Left cord and subglottic extension T2, N0, M0.	6500 r/33 fractions 45 days.	Local failure—14 months. Dose relatively low	Laryngectomy.	Stomal recurrence at 24 months. Died of disease at 27 months.
W. B.	54	Bilateral false cord T2, N0, M0.	6200 r/22 fractions 28 days	Local failure 15 months. Fields probably inappropriately small.	Laryngectomy.	Stomal recurrence 28 months. Radiotherapy and 5-FU; no evidence of disease 189 months.
L. N.	78	Left false cord, posterior epiglottis T2, N0, M0.	6600 r/33 fractions 47 days.	Metastatic neck nodes at 12 months outside radiation field. Primary controlled.	Surgical treatment not possible because node location.	Alive with disease at 16 months.
J. H.	71	Left false cord and epiglottis T2, N0, M0.	7000 r/35 fractions 46 days.	Local failure at 18 months. Unable to determine cause.	Laryngectomy.	No evidence of disease at 45 months.
E. P.	75	Right false cord and true cord. T2, N0, M0.	6000 r/30 fractions 40 days.	Local failure at 9 months. Field size inadequate.	Right laryngofissure.	Recurrence at 31 months. Total laryngectomy. No evidence disease at death from myocardial infarction at 31 months.

Discussion

An attempt was made to analyze the cause of treatment failure in the eight patients who had recurrence. Two of the stage I patients who failed were treated with doses of 6000 rad during the earlier years of this study. A dose of 6000 rad in six weeks has been shown to be inadequate by other authors.[1,2] Doses which have a greater biological effect would now be employed, for instance 6000 rad in five weeks or 6600 rad in six weeks.[1,2] The third patient who had a recurrence with stage I disease was thought to possibly have failed because the radiotherapy port was inadequately small. A review of radiographs showed that subglottic extension was present which was not appreciated at the time of treatment. Therapy portals would have been modified with this knowledge.

There were five failures in stage II. Four of the failures were supraglottic primaries which have been shown to have a poorer prognosis than glottic cancer.[2] Three patients were thought to have had doses which were too low, or field sizes which were too small. Another patient developed cervical node metastases outside acceptable radiation therapy portals.

All failures were detected within two years of treatment. In a larger series, Fletcher[2] has noted that 90% of recurrences at the primary site are seen within 24 months. It had previously been our policy to see patients in follow-up every two to three months after the first year. But this review indicates that patients should be seen at intervals no longer than six to eight weeks during the first three years. It is hoped that frequent follow-up will detect recurrences early, increasing the chances of surgical salvage.

In this series, three patients with stage I glottic cancers developed recurrences. All three were treated with a total laryngectomy and one was ultimately salvaged. In stage II, four patients with supraglottic primaries developed recurrences. Three were treated with a total laryngectomy and all were salvaged with follow-up times of 31, 45, and 189 months. The fourth patient developed massive cervical metastases which could not be treated surgically. The single patient with stage II glottic cancer who failed radiotherapy ultimately died of disease despite a laryngectomy. Overall, four patients of the eight who failed have been salvaged by surgery. Other authors have shown that laryngectomy[3] and occasionally hemilaryngectomy in selected patients[3,4] can salvage a significant number of patients who fail radiotherapy. Ballantyne and Fletcher[3] reported that only 18 of 78 patients with early stage glottic cancers who developed recurrence post radiotherapy were not salvaged by surgery.

Radiotherapy has successfully been used to treat patients with carcinoma of the larynx. The treatment is without morbidity or significant complications. The patient's voice is preserved. Only eight failures have occurred since 1960, and four patients were salvaged with surgery. Radiation therapy is a highly effective therapy for early stage carcinoma of the larynx and should be considered as the primary treatment of choice.

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ABSTRACT WISCONSIN AUTHORS

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Metrizamide: a new contrast medium for neuroradiology in children

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An ideal contrast agent for positive-contrast myelography and ventriculography is not available. The most frequently used agent, iophendylate (Pantopaque), is not soluble in cerebrospinal fluid and may produce meningeal inflammation or arachnoiditis. Oily and gaseous media often do not delineate small structures well. Most water-soluble agents tested to date have been poorly tolerated by the nervous system because they are hypertonic ionic compounds.

Recently, metrizamide (2-3 [acetamido -5-N-methylacetamido - 2, 4,6, triodobenzamido] - 2 - deoxy - D glucose) has been undergoing clinical investigation. Metrizamide is a water-soluble, non-ionic contrast medium with low osmolality. It has provided significant advantages of safety and efficacy over currently available contrast media for myelography in adults.

Twenty children from early infancy through adolescence have had myelography or ventriculography with metrizamide. Cases have included developmental anomalies of the central nervous system, hydrocephalus, posterior fossa malformations, intrinsic and extrinsic spinal cord tumors. Metrizamide has provided accurate diagnostic information in all these types of disorders. Illustrative cases will be presented. No significant side effects have been encountered, although transient vomiting or headaches may occur. This agent provides excellent definition of the spinal subarachnoid space and of the ventricular system. Metrizamide is proving to be a safe, effective contrast agent for neuroradiologic investigations in children and adults. ■

Anergy and amebic liver abscess

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ANERGY HAS BEEN observed to occur during the course of multiple infectious diseases, including some parasitic infections.[1-4] Patients with hepatic amebic abscesses have shown immunologic tolerance to *Entamoeba histolytica* antigen.[5] We recently observed a patient with an amebic liver abscess who developed anergy during the acute phase of the infection. Antibody titers against *E. histolytica* were diagnostic by counterimmunoelectrophoresis (CIE) but not by indirect hemagglutination (IHA). After three weeks of successful therapy, the patient showed return of delayed hypersensitivity, as measured by skin tests.

Case Report

A 24-year-old Mexican male, foundry-worker, was admitted to the hospital after a five-day history of epigastric pain, fever, cough, vomiting, and bloody diarrhea. The patient had lived in the United States for the past four years; his last visit to Mexico was two years before his illness. There was a history of contact with his grandfather who had tuberculosis, and the patient had been tuberculin skin test positive for several years.

Physical examination revealed an acutely ill appearing man with a temperature of 39.2 C (102.6 F). Breath sounds were decreased at the right base. The liver was enlarged (17 cm span) and tender.

Laboratory results included a hematocrit reading of 39.3% and a white blood count of 11,900 per cu mm with a shift to the left. Hepatic function studies showed albumin of 2.4 g/dl, SGOT 85KU, SGPT 75 IU/L, total bilirubin 1.2 mg/dl, and normal alkaline phosphatase. A proctoscopic examination was within normal limits. Nine examinations of stools for ova and parasites were negative. A liver scan revealed a large solitary defect in the right lobe. An echogram of the liver revealed an echo-free area in the right lobe, approximately 10 cm in diameter, with an estimated volume of fluid of 500 to 600 ml. The CIE titer for amebiasis (*E. histolytica* axenic antigen HK9; ICN, Irvine, CA) was 1:16 ($\geq$4 is positive in invasive amebiasis[6]) and the IHA titer (done at the Communicable Disease Center, Atlanta, GA) was 1:128 (which is considered borderline positive). Subsequent determinations were 1:64 and 1:2048 respectively. The "T" cell rosette ratio was 70% (N=61-80%), and the "B" cell rosette ratio was 16% (N=18-33%). Immunoglobulin determinations revealed IgG of 2050 mg/dl, with normal IgM and IgA (Behring Diagnostics, Somerville, NJ). CH_{50}, C3 (Behring Diagnostics) and C4 (Meloy, Springfield, MA) were within normal limits. Tuberculin, (PPD-5TU), trichophytin, candida, mumps, and histoplasmin skin tests were applied and were negative at 48 hours.

On the seventh hospital day, oral treatment with metronidazole, 750 mg every eight hours, was begun. Although initially a rapid clinical improvement was observed, low-grade fever and epigastric pain persisted during the 10-day course of this medication. On the 16th hospital day, emetine hydrochloride, 65 mg per day intramuscularly, was begun. Within 72 hours the patient became afebrile and the epigastric pain subsided. Emetine was continued for 10 days, at the end of which time, the patient was asymptomatic.

Because a liver scan and echogram revealed minimal reduction in the size of the abscess (despite excellent clinical response), needle aspiration and biopsy were performed on the 28th hospital day. The aspiration yielded 200 ml of non-foul smelling, cream-colored fluid. The biopsy was compatible with amebic liver abscess; however, trophozoites were not seen. The patient was discharged on the 30th hospital day on chloroquine disphosphate, 250 mg orally every eight hours, to be continued for 20 more days. Physical examination on a follow-up visit three weeks later was normal. A liver scan at this time revealed considerable reduction in the size of the abscess. Reevaluation of delayed cutaneous response with the antigens previously used showed PPD-5TU, 17 mm; trichophytin, 12 mm; candida, 10 mm; mumps, 18 mm; and histoplasmin was negative at 48 hours.

Discussion

Failure to manifest a cell-mediated immune response as measured by migration inhibition factor production (MIF) and a skin test to *E. histolytica* antigen, while retaining the capacity to respond normally to other antigens has been observed in patients with a hepatic amebic abscess during the acute phase.[5] Humoral immunity, as determined by the detection of antibodies against *E. histolytica*, appears normal in the early stages of infection. In our patient we observed a failure to react to tuberculin antigen (PPD-5TU) which previously gave a positive skin test, and to some other antigens commonly used in the assessment of delayed hypersensitivity. After completion of successful therapy, positive delayed cutaneous reactivity was observed to the previously used antigens, except for histoplasmin. Since the patient had never lived in an endemic area, it is likely that he had not been exposed to *Histoplasma capsulatum*.

Current concepts of cell-mediated immunity suggest that the lymphocytes, mainly "T" cells, act as the mediators, and the macrophages as the effector cells of this type of immunity.[7] "T" cell deficiency, macrophage dysfunction, and a functional suppression of the "T" lymphocytes are speculative causes of anergy.[8] It has been proposed that production by the "B" cells of some agents (antibodies) may either directly or indirectly suppress the normal function of the "T" cells.[9,10] The production of anergy in our patient may have been due to a primary antibody re-

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sponse (IgM). In studies to be reported we have shown that CIE detects both IgM and IgG antibodies, whereas IHA characteristically detects only the IgG antibody.

Increased knowledge and understanding of the mechanisms of CMI and humoral immunity, and their inter-relationships in patients with amebiasis may prove helpful in the future in developing an effective vaccine and selecting more specific forms of therapy (such as immunotherapy).

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ABSTRACTS WISCONSIN AUTHORS

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Francis M Forster, MD, Madison, Secretary for Continuing Medical Education

Atrial myxoma in childhood —a neurological spectrum

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Atrial myxomas are a rare, but important cause of acute and recurrent neurological disease. Their importance lies in the ease of diagnosis and potential for complete cure when the condition is suspected.

A 14-year-old girl presented with acute right hemiparesis, expressive aphasia, and blindness of the left eye. Because of recurrent embolic pneumonia, cardiac catheterization was performed and revealed a left atrial myxoma which was subsequently removed with a portion of the septum. No new symptoms appeared until four years later when she presented with the acute onset of vertigo and diplopia. Echocardiography and cardiac catheterization confirmed a recurrence of the myxoma. At surgery, the tumor and septum were removed and the latter replaced by a Dacron patch. She has done well the past three years.

Atrial myxomas are rare cardiac tumors in children. Of 31 children with left artial myxomas, 25% presented initially with acute neurological syndromes (coma, blindness, stroke) and an additional 31% developed neurological complications (stroke seizures, paresthesias) before diagnosis. Clinical suspicion, echocardiography, and cardiac catheterization are successful in establishing the diagnosis. Complete excision of the atrial septum and replacement with a Dacron patch is advisable as there are now eight reported recurrences of the tumor after partial septectomy. ■

Alpha coma: report of eleven cases

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Eleven patients with alpha coma, ranging in age from 19 to 81 years, were studied. Etiologies were as follows: Diffuse anoxia - 5, brain infarction - 2, head injury - 3, and drug intoxication - 1.

One patient from each group survived. EEG criteria previously reported as indicating a favorable prognosis, namely, reactivity of background activity and the presence of sleep-like rhythms were absent in 3 of these. Non-reactive alpha frequency background was recorded until almost complete recovery in 1 patient with diffuse cerebral anoxia. In cases in which serial EEG recordings were available, a sequence from an EEG background consisting of alpha frequencies to diffuse slow rhythms tended to indicate a poor prognosis. Distribution of alpha frequencies was not a predictor of outcome.

Abnormalities ranged from diffuse non-structural disturbances to focal and multifocal lesions involving cerebral cortex, corpus callosum, thalamus bilaterally, and brain stem.

We conclude: (1) That alpha coma may occur due to a variety of causes. (2) That location and nature of lesions and distribution of alpha frequencies are poor predictors of outcome. (3) That patients in alpha coma may recover. (4) That when diffuse delta frequencies supercede alpha frequencies, the outcome is poor. ■

Genetic study of focal seizures

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The authors reviewed the data on 1,000 patients with epilepsy undergoing active treatment. There is a high incidence of focal seizures as shown by clinical and EEG evidence. There is also a high incidence of positive family histories for epilepsy, and among those with a family history of epilepsy over half of them had first degree relatives with seizures.

The authors studied 23 families of which two or more members had clinical seizures. In 13 families EEG abnormalities were similar, and in 10 families EEG abnormalities were dissimilar.

It is not clear what the factors are which cause the EEG focal abnormalities to be similar or dissimilar. The data suggest that genetic factors operate in focal epilepsy. This agrees with previous authors. Metrakos suggested that the genetic component in epilepsy is polygenic, and the disease produced is multifactorial, and our data support this. As a working hypothesis, independent genetic components probably include: (1) photosensitivity; (2) the 3/Sec. generalized spike-and-wave EEG trait, with age-dependent penetrance; (3) a low convulsant threshold [the "Threshold Genes" of Metrakos]; (4) abnormal theta rhythm markedly dependent on age [between 2 and 7 years] noted by Doose et al, and possible others. Further long-term studies, including EEGs on clinically-normal relatives of patients with seizures, are required for genetic counseling to be based on reliable data. ■

A late complication of tracheostomy

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• A patient with a convulsive disorder who had acute respiratory distress necessitating a tracheostomy is presented. Sixteen days later the patient died due to massive exsanguination. Pictorial autopsy findings illustrate a fistula between the innominate artery and the trachea, which is a late complication of tracheostomy.

A LATE COMPLICATION of tracheostomy is an erosion of the trachea and innominate artery resulting in hemorrhage with aspiration and exsanguination.[1-6] The incidence of delayed hemorrhage was recently reported in a series by Chun and Cantrell as 0.36% with a 10% mortality.[1] The purpose of this paper is to present one such case illustrating the gross and microscopic findings at autopsy and the probable etiologic factors.

Case Report

The patient was a 59-year-old white male with a history of chronic brain syndrome with a convulsive disorder and right hemiparesis secondary to brain trauma. In November 1972 the patient had an acute upper airway obstruction when he aspirated a bolus of meat. He was admitted to a local hospital in acute respiratory distress. A laryngoscope was inserted, and the meat impaction was removed. Cardiac activity and respirations were restored with resuscitation, but there was an interval of 20 minutes before it was accomplished. Thereafter the patient remained unconscious and responded

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Figure 1—Trachea from behind showing erosion of its anterior wall.

Figure 2—Innominate artery open from in front with probe at site of erosion.

Figure 3—Rupture site of innominate artery (25X).

only to painful stimuli. He did not improve during the subsequent hospital course and remained in a deep coma. After having an endotracheal tube present for six days, tracheostomy was performed under local anesthesia using a No. 36 single cuffed portex tube. He had continuous seizure activity during further hospitalization. Sixteen days later, while the tracheostomy tube was being changed, he began bleeding profusely from the tracheal stoma. Despite suctioning and pressure the bleeding could not be controlled. He died in respiratory arrest.

Autopsy findings correlated with the clinical impression and confirmed that the patient died of acute suffocation from massive aspiration of blood. The origin of the hemorrhage was the innominate artery which is shown by the probe in Figure 1. The innominate artery was located posteriorly under a large area of erosion of the tracheal wall. The area of erosion was approximately 2 cm below the tracheostomy. The 4-cm erosion encircled the lumen of the trachea and was sharply demarcated. The trauma appeared to have been produced by the balloon because the area of necrosis was similar to the No. 36 single inflated portex cuff. There was thickening and fibrosis of the peritracheal tissue in the area of the erosion. In the center of the tracheal erosion a probe in a small opening, approximately 0.5 cm in diameter, connects the trachea with the innominate artery (Fig 2). The bronchial tree was filled with partially clotted, recently extravasated blood. The clots were removed before the photographs were taken.

Microscopic findings at low magnification (25X) show marked extrinsic erosion that penetrates into the wall of the innominate artery. The area of rupture can be clearly seen (Fig 3).

Comment

One or a combination of etiologic factors can be involved in erosion of the trachea into the innominate artery. A low tracheostomy, an elevated innominate artery, infection, pressure from the tip or cuff of the endotracheal tube, an excessively long or angulated tube, excessive tube motility, and/or a poor fitting tube are to be considered.

The patient had an endotracheal tube present for six days and a tracheostomy tube present for 16 days. A No. 36 single cuff portex tube was used. The tube was changed every other day and the cuff was deflated five minutes every hour. The tracheal stoma was located between the third and fourth rings. The innominate artery was located in its normal position. The trachea, distal and proximal to the erosion, showed no abnormalities. There was no significant arteriosclerosis of the innominate artery. The probable etiologic factors present in this patient were frequent seizures with tube motion, constant suctioning, and the need for an inflated cuff.

Detailed attention to tracheostomy care is essential. The present case demonstrates the need for meticulous tracheostomy care for an unconscious patient who is undergoing continuous seizures.

Summary

A case of sudden death from massive hemorrhage due to erosion of the trachea into the innominate artery following tracheostomy is

Changing pattern of ringworm infections

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In mid-November 1976, a first grade Milwaukee school girl developed tinea circinata (ringworm) of the face. She was diagnosed and treated by a dermatologist who cultured *Trichophyton tonsurans* from the lesion. In rapid succession, other cases of ringworm of the skin appeared in the same classroom. This was followed by occasional cases in other rooms.

This school is of recent origin with carpeted classrooms. Audio-visual equipment with earphones is used by the children. It is located in an outlying middle income area with a predominance of single-family dwellings. The total enrollment is 550, of which 125 students are bussed from the central city.

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A screening program was begun to determine the incidence and source of these infections. Past experience in similar conditions has shown undetected scalp ringworm as an important source of *Tinea circinata (glabrosa)*. Endothrix infections (inside shaft of hair) do *not* fluoresce under the Wood's lamp and, therefore, use of the lamp was not helpful. In rooms where skin lesions were noted, the scalps of all the children were inspected. No typical endothrix hair loss (hairs broken off flush with skin) was initially noted. A few of the children had minimal findings suggestive of seborrheic scaling. Combed specimens of hair and scalp were submitted to the laboratory for culture.

Positive cultures were obtained from scalps of three first graders. When the specimens were collected, these scalps did not show clinical signs of obvious ringworm. Two of these children were in the room where outbreak was first noted and the third was a sibling of one of these students but in an adjacent class. These children were of the "bussed-in" group. By the time the cultures were reported (four weeks), two of the children exhibited typical endothrix type of hair loss. To date there have been 15 cases of tinea circinata and three cases of *Tinea capitis*. *T. tonsurans* was the only pathogenic dermatophyte identified. Prior to 1960, *T. tonsurans* was infrequently cultured in our school surveillance program. In 1965, approximately 30% of the total cultures identified were *T. tonsurans*. Since 1972, *Microsporum audouini* has rarely been cultured (one or two per year) and *T. tonsurans* has become the principal endemic organism responsible for skin and scalp fungal infections of Milwaukee school children.

The skin lesions were predominantly on the face, neck, and exposed extremities. In most cases, the lesions were nummular, circular, sharply circumscribed, slightly erythematous, dry, scaly patches characteristic of tinea circinata. Positive microscopic (KOH) examinations and cultures were obtained in these cases. The carpeted floors may be a factor in the spread of disease. In lower primary classes, activities frequently involve students sitting on the floor. Lesions on the cheeks and about the ears suggest earphones as possible fomites. Roller towelling in the lavatories may also have played a role. None of the involved children used the mats in the gymnasium.

Since the clinical findings were sometimes minimal, especially in the scalp cases, difficulty was encountered in getting treatment in spite of our positive cultures. A recent unrelated case of a kerion due to *T. tonsurans* was unrecognized and treated with penicillin in an outpatient department of a local hospital. The lesions of *T. tonsurans* of scalp are variable and one should keep a high index of suspicion of *T. tonsurans* infection. Both hair and scale specimens should be submitted for laboratory diagnosis. *Tinea capitis* requires four to six weeks of griseofulvin therapy. Skin lesions respond quite rapidly to any of the popular topical fungicides.

It is our recommendation that where *Tinea circinata* is encountered, a scalp source should be sought by culture to rule out *Trichophyton tonsurans* and *Microsporum audouini*. At the present time infections by *T. tonsurans*, which do not fluoresce to Wood's lamp, are the most common. ■

Tracheostomy/continued

presented. Emphasis is placed on gross and microscopic findings at autopsy.

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Giant cell arteritis and visual loss

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• A review of the University of Wisconsin Hospital records yielded 15 patients who experienced permanent visual loss as a complication of giant cell arteritis. Nine of those patients had prior symptoms of the polymyalgia rheumatica syndrome. Recognition of this condition and initiation of corticosteroid therapy may prevent devastating visual loss and will reverse debilitating symptoms experienced by these older patients.

GIANT CELL ARTERITIS (temporal arteritis) is an important disease for the primary physician to recognize because prompt treatment of this affliction of the elderly can prevent blindness and relieve debilitating symptoms.[1-4] Between 1972 and 1976, fifteen patients with giant cell arteritis and resultant loss of vision have been seen by the University of Wisconsin ophthalmology staff.

The purposes of this paper are: (1) to review the clinical course of 15 patients with visual loss and positive biopsies for giant cell arteritis; (2) to stress the close association of the polymyalgia rheumatica syndrome[2,3,4] to giant cell arteritis and to review the criteria for diagnosing the polymyalgia rheumatica syndrome; and (3) to emphasize that visual loss can probably be prevented in these syndromes by prompt corticosteroid treatment.

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Methods

Our hospital files provided the names of 15 patients who had biopsies of the superficial temporal artery establishing the diagnosis of giant cell arteritis, and who had recent onset of visual impairment with visual acuity of 20/50 or less or with loss of at least one quadrant of visual field. The hospital records of these patients were reviewed, and 11 of the 15 patients were interviewed again. Special attention was given to the signs and symptoms prior to the loss of vision and to the clinical and laboratory data at the time of diagnosis. The Wintrobe method was used to measure the erythrocyte sedimentation rate (ESR). Patients were considered to have the polymyalgia rheumatica syndrome if they fulfilled the criteria shown in Table 1.

Results

Table 2 summarizes the results. Among the 15 patients, there were 4 men and 11 women whose ages ranged from 65 to 86 years, and averaged 74 years. Headache was a prominent symptom in 12 of the 15 (80%) and had been present an average of 2.3 months prior to the onset of visual loss. The headache was usually of a continuous boring nature with occasional sharp or throbbing pains. Scalp tenderness that might prevent the patient from resting the head on a pillow or brushing the hair was a symptom in 11 of the 15 patients (73%). For example, a 67-year-old lady had headache and scalp tenderness which progressed in a month to the point that she had her hair cut very short to avoid the pain produced by brushing or shampooing her hair. During this time three physicians had seen her and con-

Table 1—Characteristics of polymyalgia rheumatica

THE POLYMYALGIA RHEUMATICA SYNDROME[2-4]
1. Pain and stiffness in proximal limbs.
2. Systemic symptoms of fever, lassitude, and weight loss.
3. Elevated erythrocyte sedimentation rate.
4. Absence of objective signs of muscle disease; *ie,* normal muscle biopsy and serum enzymes (creatine phosphokinase and glutamic or pyruvic transaminase).
5. Dramatic clinical response to corticosteroid therapy.

Table 2—Clinical summary of patients studied

Patient	Age	Sex	Head-* ache	Jaw Claudi- cation	Polymyalgia rheumatica: Proximal muscle* pain & stiffness	Polymyalgia rheumatica: Fever	Polymyalgia rheumatica: Weight loss in pounds	Visual acuity on admission: OD	Visual acuity on admission: OS	ESR mm/hr
1	73	F	8	+	8	+	21	2/200	3/200	49
2	83	F	years	–	–	–	–	NLP	NLP	43
3	82	M	8	–	–	–	6	HM	20/40	54
4	67	F	14	+	–	–	–	20/30	LP	43
5	76	F	14	+	12	+	25	20/50	20/50	54
6	77	F	–	–	24	+	14	17/200	20/40	51
7	68	M	7	–	24	+	–	20/20	NLP	54
8	65	F	3.5	+	–	–	–	20/15	20/100	35
9	86	F	6	–	–	–	–	20/80	20/70	53
10	70	M	0.5	–	3	–	–	LP	20/20	#
11	75	M	–	+	14	+	22	20/50	NLP	60
12	67	F	3	+	36	–	15	20/20‡	20/20‡	55
13	80	F	–	–	0.5	–	–	20/70	NLP	50
14	67	F	3	+	5	+	–	20/50	CF	60
15	72	F	12	+	–	–	–	CF	20/40	55
Totals or Average	74	11F 4M	12 pts 9 wks	8 pts	9 pts 16 wks	6 pts	6 pts			51

*Duration of symptoms prior to visual loss, expressed in weeks.
#Four days prior to admission, patient 10 was begun on steroid therapy elsewhere without measurement of ESR.
‡Patient 12 had normal vision upon admission to hospital, but became blind in each eye four days later.
Abbreviations: F, female; M, male; +, present; – not present; pts, patients; OD, right eye; OS, left eye; NLP, no light perception; LP, perception of light only; HM, hand movement recognition; CF, finger counting ability; ESR erythocyte sedimentation rate.

sidered her headaches to be migrainous. Shortly thereafter, she was admitted to our hospital with acute loss of vision in the left eye and blurred vision in the right eye. With prednisone therapy, her visual status remained stable although she was left with no light perception in the left eye.

Another symptom that is virtually pathognomonic of giant cell arteritis is jaw claudication, jaw pain provoked by mastication.[2] This symptom was present in 8 of 15 patients in our series.

Nine of the 15 patients had the polymyalgia rheumatica syndrome. Six of these 9 patients had both fever and weight loss. One representative patient was a 68-year-old attorney admitted to our hospital in May 1974. For six months he had experienced progressive weakness and fatigue. Eight weeks prior to admission he developed severe intermittent frontal headaches and four weeks later the onset of fever and chills. The headache worsened to the point that he was hospitalized and placed on antibiotics for a possible sinus infection. After one week of treatment, he developed diplopia and one day later became blind in his left eye. The ESR was elevated (54 mm/hr) and the temporal arte.y biopsy was positive for giant cell arteritis. He has been treated with corticosteroids for two years. Vision in the right eye has remained normal, but blindness of the left eye has persisted.

Visual loss often facilitates the recognition of giant cell arteritis. To be included in our series, all patients had significant visual loss in at least one eye. Three of the 15 (20%) had bilateral visual loss, and 12 patients sustained unilateral involvement. The mechanism for the visual loss in 10 (66%) of our patients was ischemic optic neuritis, characterized in the acute phase by a pale swollen optic disc often associated with peripapillary hemorrhages (Fig 1). Two patients had scattered retinal cotton wool patches, the manifestations of ischemia of the nerve fiber layer of the retina. One patient had a central retinal artery occlusion, and one patient had no visible ocular lesions. One patient had cataracts which prevented adequate view of the fundi. The visual impairment of the affected eyes was generally permanent. Visual improvement occurred in only one patient whose visual acuity increased from 20/50 to 20/20. Loss of vision was noted in one patient two days after initiation of corticosteroid treatment.

Transient episodes of monocular decreased vision (amaurosis fugax) were noted by 5 of the 15 patients (33%). These all occurred within one week of the acute loss of vision. Prior to visual loss, diplopia occurred in 3 (20%) of the 15 patients studied.

The most sensitive laboratory test suggesting this condition is the erythrocyte sedimentation rate (ESR).[2] The mean ESR (by Wintrobe technique) for our patients was 51 mm/hr, with a range from 35 to 60 mm/hr. Four patients had slight anemia and five

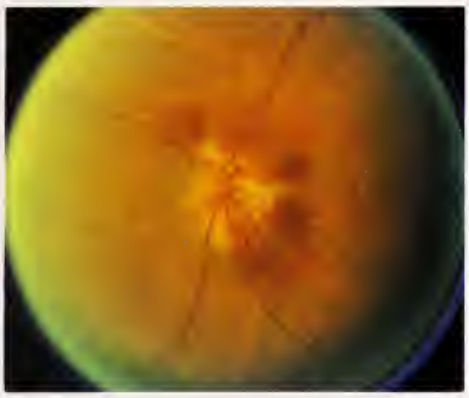

Figure 1—Ischemic optic neuritis. The disc is swollen and pale with peripapillary hemorrhages.

Figure 2—Markedly swollen temporal arteries. The arteries, at times, are very tender and cord-like.

had moderately elevated white blood cell counts (10,000-13,000/cu mm).

Comment

The clinical features of our patients are consistent with previous descriptions of patients with giant cell arteritis.[1-5] The patients are over 55 years of age and most complain initially of malaise, weight loss, fever, aching of the neck and shoulders, and later of headache, scalp tenderness, jaw claudication, prominence of temporal arteries (Fig 2) or visual loss. The early symptoms are typical of polymyalgia rheumatica. It has been shown that approximately 40% of patients with polymyalgia rheumatica syndrome who do not have complaints suggesting cranial artery involvement also have temporal artery biopsies characteristic of giant cell arteritis.[3]

It also has been shown that the arteries frequently involved by the arteritis are the aorta, vertebral, ophthalmic, and posterior ciliary arteries.[6,7] The latter two groups account for the profound visual loss that can occur in patients with untreated giant cell arteritis. The most common mechanism for the visual impairment is ischemic optic neuritis, caused by an inflammatory thickening of the walls of the posterior ciliary and ophthalmic arteries, and resultant compromise in perfusion of the distal optic nerve.[8] One suspects that a significant percentage of untreated patients with polymyalgia rheumatica eventually have involvement of the arteries perfusing the eye and thereby experience the visual consequences typical of giant cell arteritis.

While there is no specific laboratory test for temporal arteritis short of artery biopsy, an elevated ESR supports the diagnosis. With strong suspicion of the disorder, the ESR test result should be obtained immediately. Recent marked visual loss strongly suggests the presence of giant cell arteritis. Although the superficial temporal artery biopsy may be omitted in a 'typical" patient with giant cell arteritis, this relatively innocuous procedure is very helpful in justifying the prolonged corticosteroid treatment that patients with giant cell arteritis require.

High dose corticosteroids (60-80 mg prednisone/day) have been dramatically effective in suppressing the inflammatory process with marked improvement of the systemic symptoms within one or two days of the initiation of treatment. Although vision generally remains stable once corticosteroid therapy is initiated, other authors have reported progressive visual loss during corticosteroid treatment[1,2] as occurred in one patient in our series. However, the incidence of unilateral blindness progressing to bilateral involvement is decreased by 50% with prompt corticosteroid treatment.[1] Corticosteroids are regulated according to the ESR and clinical symptoms. Daily dosage that has been tapered down to 10-30 mg daily over several months is generally required. Most authors recommend treatment for at least six months and many patients require treatment for more than two years.[2] Six patients in our series continued on prednisone for more than 1.7 years following diagnosis.

It is very important that a high level of suspicion must be maintained if this disorder is to be recognized and appropriate corticosteroid treatment to be initiated prior to the development of permanent visual loss.

ACKNOWLEDGMENTS: We are grateful to Dr Rodney Sturm for permitting us to review several of his patients.

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Clear cell sarcoma of tendons

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• **A case report of the rare clear cell sarcoma is presented. The histology and clinical features of this tumor are discussed and recommendations regarding treatment given.**

In 1965 Enzinger[1] called attention to a previously undescribed sarcoma arising from large tendons and aponeuroses of the extremities. These tumors displayed a characteristic structure which was unlike any previously recognized malignant tumor associated with these tissues. Since that time, other reports have appeared in the literature confirming the rarity of this unusual malignant lesion.

Case report

A 24-year-old white male, previously healthy, was admitted to the hospital for excisional biopsy of a firm mass noted on the ulnar aspect of the right forearm just above the wrist. The lesion had been present for approximately three and one-half years; it had not changed appreciably in that time except for the development of mild tenderness. The patient had consulted a physician approximately three years prior to admission, but he was advised at that time to take no definitive action regarding the mass.

Physical examination was completely within normal limits with the exception of the presence of a firm mass measuring approximately 3 cm in its greatest diameter, located on the ulnar aspect of the right forearm approximately 10 cm above the ulnar styloid process. Mild tenderness was present. No palpable lymph nodes were present in either the epitrochlear or axillary regions. X-ray film taken of the forearm revealed the presence of a mild indentation along the lateral aspect of the ulna (Fig 1). A chest x-ray film was reported as normal.

The patient initially underwent excisional biopsy of the lesion; and the frozen section report was that of a malignant sarcoma, type undetermined. He subsequently underwent an en bloc excision of the middle third of the right forearm, including the ulna and a large portion of the ulnar nerve. The bony defect was repaired with bone grafts obtained from the right seventh rib and right iliac crest with intramedullary fixation (Fig 2). The soft tissue defect was covered with a pedicle flap from the abdominal wall. In addition, an axillary dissection was carried out. The final

Figure 1—Preoperative x-ray film showing slight indentation of ulna.

Figure 2—Postoperative x-ray film showing soft tissue defect and bone graft.

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pathology report on the resected specimen of the forearm showed no residual evidence of neoplasm, and 26 axillary lymph nodes were negative for metastatic tumor. The final diagnosis was clear cell sarcoma of tendon origin.

The abdominal pedicle flap was released approximately four weeks after the initial surgery, and healing progressed satisfactorily. The patient did well until approximately ten months after the initial diagnosis, at which time he was admitted to the hospital complaining of progressively more severe back and posterior chest pain. X-ray films revealed a compression fracture of the seventh thoracic vertebra, and planigrams obtained of the dorsal spine revealed an associated paraspinal soft tissue mass.

The patient received radiation therapy to the spine with some relief of symptoms. In addition, he was treated with actinomycin-D, cyclophosphamide (Cytoxan®), and vincristine. However, he continued to do poorly, and he very rapidly developed evidence of metastases to the right glenoid fossa, both lungs, and the brain. He died approximately 13 months following the initial diagnosis. Permission for autopsy was refused.

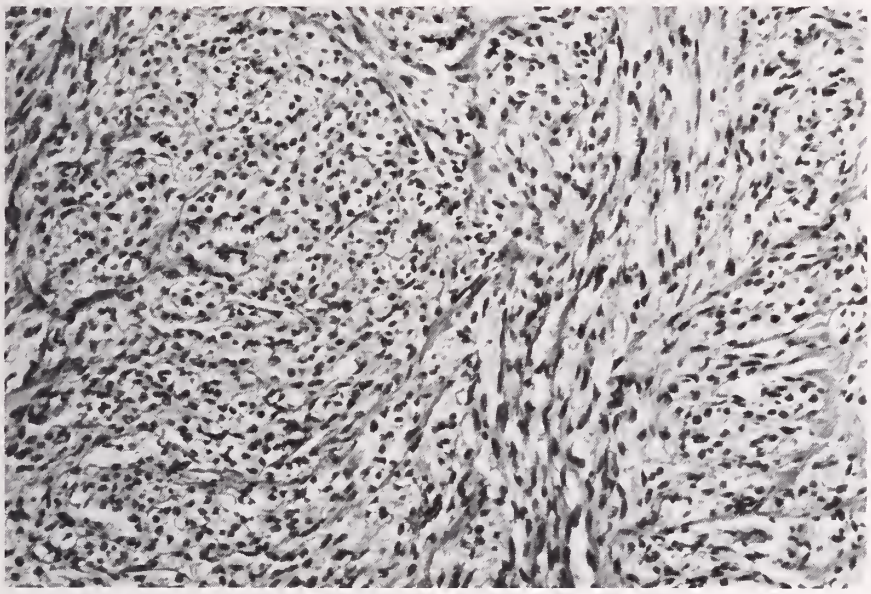

Figure 3—Photomicrograph illustrating cellular aggregates with fibrous tissue septa (H&E 160x).

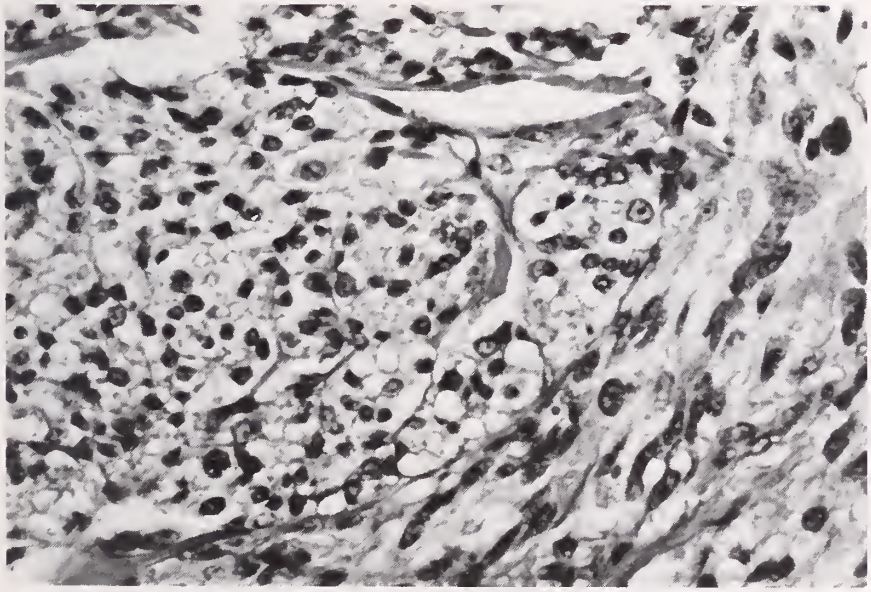

Figure 4—Cellular detail (H&E 400x).

Pathology. The initial excisional biopsy revealed a 2 cm in diameter roughly spherical, somewhat lobular-appearing tumor composed of rather homogenous yellow-white firm tissue containing occasional chalky areas within it.

Microscopic examination revealed the tumor to be composed of rather compact-appearing nests and clusters of elongated cells having an epithelioid appearance (Figs 3,4). The aggregates of cells were surrounded by delicate traversing septa of fibrous connective tissue, which were ocasionally contiguous with the denser collagenous tissue within the tumor. The tumor cells were closely approximated with indistinct peripheral cytoplasmic margins and amphophilic to occasionally mild acidophilic staining characteristics. The cellular nuclei were round to oblong, and had readily discernible nucleoli. Nuclear chromatin pattern was fine and rather evenly distributed throughout the nucleoli. The cytoplasmic component of the cells varied from being clear to finely granular and sometimes vacuolated. Mitotic figures were infrequent, and a rare multinucleated giant cell was encountered. Occasional small vascular channels were encountered randomly distributed throughout the lesion, although the overall vascularity of the lesion was unimpressive.

Discussion

The clear cell sarcoma is a very uncommon lesion, as indicated by Enzinger's report of 21 cases collected over a 25-year period from the AFIP. Angervall and Stener[2] reported four cases collected over a 20-year period in Sweden. The microscopic appearance of these tumors as described by Enzinger and others agrees closely with the histologic description in this case. The term clear cell sarcoma of tendons and aponeuroses chosen initially by Enzinger was purely descriptive in nature, as was pointed out in his report. He emphasized the uncertainty of the tumor's histogenesis, a feature subsequently reemphasized by MacKenzie.[3]

The median age at the time of surgery reported by Enzinger was 26 years. Radiographic evidence of bone erosion was not described, although it was seen once in sections of the excised specimen. The average duration of symptoms was three and one-half years, but the range

was quite wide. In all cases reported the tumors followed a relentless malignant course, although this was quite often protracted. Most of the cases reported showed a tendency toward repeated local recurrences of the tumor prior to the development of distant metastases. This was explained partially by the fact that these tumors were initially not recognized as being quite malignant. The interval between the first operation and clinical evidence of metastatic disease ranged from several months to many years, with an average of six years. Several authors have emphasized the importance of regional node involvement and a necessity for dealing with this in planning the course of the therapy. The most common distant sites of metastases other than the regional lymph nodes were the lung, heart, liver, and brain.

Although this sarcoma is somewhat difficult to diagnose histologically, its clinically relentless course demands early recognition and aggressive therapy. It would seem that an early aggressive surgical approach to these lesions, often requiring amputation, should include the appropriate regional lymph node dissection. Experience with radiation therapy is limited, but these tumors do not appear to be radiosensitive. The use of adjunctive chemotherapy with doxrubicin hydrochloride (Adriamycin™) or high-dose methotrexate, as has been done with other sarcomas, is worthy of consideration.

ACKNOWLEDGMENT: The authors are indebted to the Department of Pathology, Mayo Clinic, for reviewing the histologic material.

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Dual occurrence of celiac sprue and idiopathic portal hypertension

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WE RECENTLY identified a patient with two rare diseases: idiopathic portal hypertension (IPH) and celiac sprue. Portal hypertension without cirrhosis on liver biopsy or without extrahepatic portal obstruction is known as idiopathic portal hypertension. Idiopathic portal hypertension is a disease of obscure etiology. We report our patient with the dual occurrence of IPH and sprue with hope that it might shed light on the etiology of IPH. Boyer *et al,* using postmortem dissection and vascular injection corrosive casting techniques, demonstrated that four cases of IPH were due to obstruction of intrahepatic portal venous radicals. The pathogenesis of this obstruction is unknown. In some cases IPH was associated with previous abdominal suppuration and pylephlebitis.[1] The diagnosis of sprue is based on the presence of malabsorption, subtotal villous atrophy on small bowel biopsy, and improvement on a gluten-free diet.

Case report

A 42-year-old white male was admitted for evaluation of a 50-lb weight loss over the previous year. Stools were loose and increased to 10 per day. Several months prior to admission a profound iron-deficiency anemia was noted by another physician. There was no history of blood loss, and oral iron therapy led to no improvement. There was no history of exposure to infections or hepatotoxic drugs.

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Physical examination revealed a pale, thin male. A systolic flow murmur was heard at the left sternal border. There was no palpable abdominal organomegaly. The remainder of the physical examination was within normal limits. The hematocrit reading was 22% with a normal white blood cell count and differential. The serum iron was 10 mg/100 ml, the iron-binding capacity was 330 mg/100 ml. Bone marrow aspiration revealed a hypoplastic marrow with absent iron stores. Stools were negative for occult blood. Total bilirubin was 0.6 mg/100 ml; albumin, 3.0 gm/100 ml; alkaline phosphatase, 178 mU/ml; SGOT, 86 mU/ml; LDH, 275 mU/ml; serum carotene, 70 μg/100 ml; BSP retention was 5.7% at 45 minutes. Hepatitis B surface antigen was not detected, and the alpha-1-antitrypsin level was normal. Upper gastrointestinal x-ray series revealed large esophageal varices and marked thickening of the mucosal folds on small bowel study. There also was dilatation, fragmentation, and flocculation. Endoscopy confirmed the presence of esophageal varices and revealed no other source of blood loss.

Superior and inferior mesenteric arteriograms showed an enlarged superior mesenteric artery with no arteriovenous malformation or other abnormality. Hepatic vein wedge pressure was normal. Liver scan revealed a defect in the right hepatic lobe. After four unsuccessful attempts at percutaneous needle biopsy of the liver, open biopsy was performed. The liver was diffusely, finely nodular with areas of fibrosis and contraction beneath the capsule. The right lobe was small and contracted. Abdominal exploration was otherwise unremarkable.

Hepatic histology from a wedge biopsy of the left lobe was unremarkable (Fig 1). Splenoportography revealed an increased splenic wedge pressure of 300 mmH_2O with a patent portal vein of normal caliber. The intrahepatic portal veins on the right

were reduced in size and the branching vessels narrowed and terminated abruptly with poor visualization of the periphery. The left lobe was faintly visualized because of the supine position. There was marked hepatofugal flow with gastric, esophageal, and retroperitoneal varices. Although the 72-hour fecal fat was 19.8 gm and D-Xylose excretion was 4.5 gm/hr, small bowel biopsy revealed subtotal villous atrophy consistent with the diagnosis of celiac sprue (Fig 2). *Giardia* were undetectable on wet mount and serum quantitative immunoglobulins were within normal limits.

On a gluten-free diet the patient gained 30 lb in three months and the hematocrit reading rose to 37%. Followup small bowel biopsy revealed improvement in the mucosal pattern (Fig 3).

Ten months after his initial evaluation the patient was doing well. At this time his serum did not stain rat liver or stomach after combination with fluorescent polyvalent human-anti-immunoglobulin.

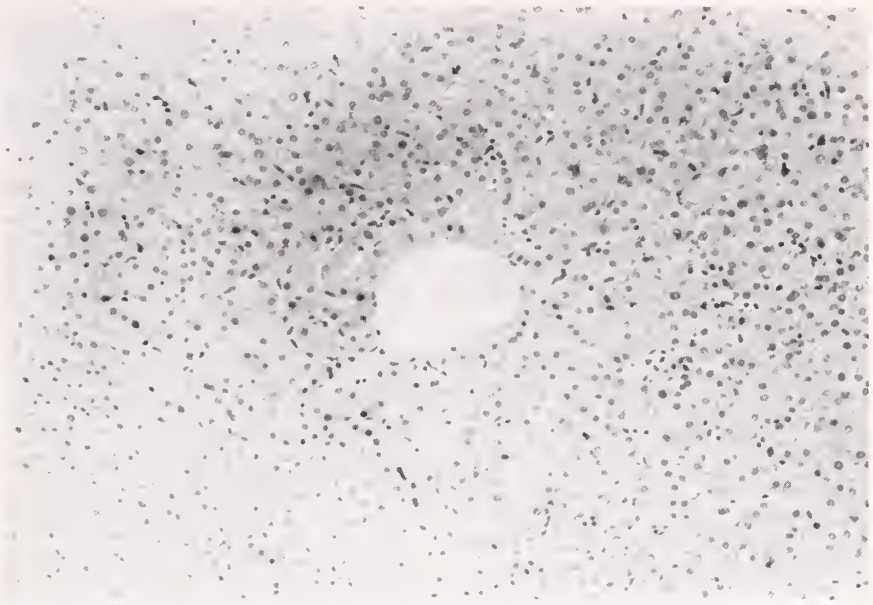

Figure 1—Hepatic histology from a wedge biopsy of the left lobe was unremarkable.

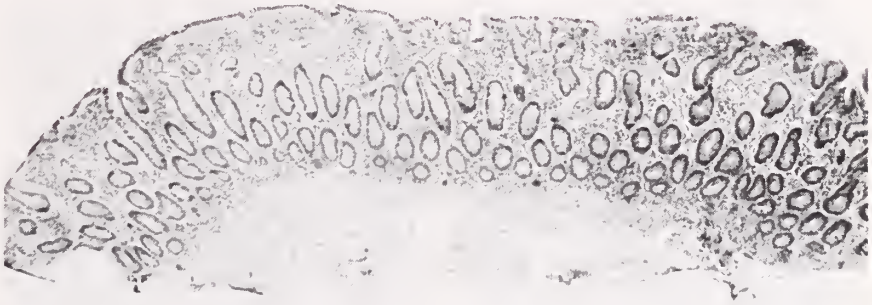

Figure 2—Small bowel biopsy revealed subtotal villous atrophy consistent with the diagnosis of celiac sprue.

Figure 3—Followup small bowel biopsy revealed improvement in the mucosal pattern.

Discussion

Our patient demonstrated portal hypertension with an elevated splenic pulp pressure of 300 cmH_2O and a normal wedged hepatic vein pressure consistent with presinusoidal obstruction. Hepatic wedge biopsy did not reveal cirrhosis and like three of Boyer's four index cases of IPH, the hepatic surface was finely nodular. We suspect the scan defect in the right hepatic lobe was due to parenchymal atrophy and collapse. Atrophy and collapse were also noted in three of Boyer's cases. Splenoportography revealed a patent extrahepatic portal vein with cutoffs of the major intrahepatic portal veins on the right with poor visualization of the periphery. This intrahepatic pattern was noted in one of Boyer's cases.[1]

The diagnosis of sprue was based on the presence of malabsorption of iron and subtotal villous atrophy on small bowel biopsy. After institution of a gluten-free diet, both parameters improved and the patient gained 30 lb.

Serum antibodies that stain rat hepatic periportal connective tissue including the adventitia of blood vessels have been detected in patients with sprue.[2] Similar staining

has been seen in human fetal livers.[3] These antibodies of IgG and IgA type have been found by indirect immunofluorescent techniques in the sera of approximately 1/3 of adults and 2/3 of children with sprue at titers of 1/10 or higher. This incidence is significantly higher than in control patients with other diseases (1.4-2.0%).[4,5] Shea suggested that the antibodies may not be detected in some sprue patients because of tissue binding. The antibodies are significantly more common in untreated patients[4] and previously detectable antibodies may become undetectable after institution of a gluten-free diet.[5,6] We did not check our patient for antibodies before gluten was removed from his diet, and they were not detected ten months after instituting therapy. Antibodies directed against the adventitia of blood vessels in portal tracts could elicit an inflammatory reaction causing obstruction of intrahepatic portal venous radicals and thus our patient's IPH.

Another mechanism possibly linking sprue to IPH is the enhanced mucosal permeability to dietary proteins present in sprue. Most authors feel that the increased levels of serum antibodies to dietary proteins, including cow's milk and bovine serum, found in sprue patients are due to increased mucosal permeability.[7,8,9] It also is suggested that gluten ingestion in sprue patients is followed by abnormally elevated serum peptide levels.[10] Antigenic proteins, otherwise sequestered in the gut lumen, enter the portal system, and may elicit an inflammatory reaction in the distal venous radicals causing obstruction and IPH.

To the best of our knowledge, sprue and IPH have never been reported in the same patient. We hope that future clinical experience will clarify the question of a pathogenic link.

ACKNOWLEDGMENT: Richard Hong, MD performed the antibody studies.

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WISCONSIN RESEARCH

Experimental drug, carnitine, may be effective treatment for some types of heart problems

Tests conducted by researchers at Middleton Memorial Veterans Hospital, Madison, indicate that an experimental drug called carnitine may be an effective treatment for some types of heart problems, according to a report from the University of Wisconsin-Madison Center for Health Sciences.

James H Thomsen and Austin L Shug, members of the UW-Madison faculty, said carnitine may increase the ability of hearts disabled by coronary artery disease to tolerate stress.

If future tests verify the findings, Thomsen said doctors may someday prescribe the drug to relieve symptoms of the disease such as chest pain and shortness of breath and to limit the severity of heart damage.

Thomsen, associate professor of medicine, and Shug, associate professor of nutritional science, emphasized that their findings are only preliminary and that final results may be years away.

"Our attitude at present is one of guarded enthusiasm," Thomsen said.

"Future tests may prove that carnitine is very beneficial for people with coronary artery disease—perhaps even more so than expected," Shug added, "but making claims now can only raise premature expectations."

Thomsen presented the findings in March at a session of the American College of Cardiology in Las Vegas. The research, funded in part by the Bio/Basics International Corporation and the National Institutes of Health, is based on animal studies conducted several years ago under the direction of Shug.

The researchers believe carnitine may provide more energy for the heart by increasing the use of fatty acids and other "fuels" used by the body. Since carnitine works by a different mechanism than drugs such as nitroglycerine, Thomsen and Shug suggest that simultaneous use of the two types of drugs may produce an additive effect, reducing the work for the heart and increasing the available energy. They said that such a hopeful outlook, however, is only an optimistic guess at this time.

Unlike many drugs tested by scientists, carnitine has been known and used for a long time. The drug was first identified and isolated from muscle tissue in 1905.

Since then, scientists have learned that the body needs carnitine to obtain energy from fatty acids and that deficiencies of the compound can cause illness. The body produces about half the necessary amount of carnitine. The rest must be gathered from the diet.

Doctors in Europe and other countries use the drug to treat many types of diseases including a specific type of muscular dystrophy and some kinds of heart disease. ■

Sarcoidosis associated with unusual neurologic deficits

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• This report calls attention to the often overlooked possibility of sarcoidosis causing or aggravating neurologic disease. Three patients in whom sarcoidosis aggravated previously existing neurologic disease were seen within a five-month period. The association of these particular deficits with sarcoidosis has seldom been reported in the literature.

INVOLVEMENT OF THE nervous system has been reported in approximately 5 percent of patients with sarcoidosis.[1-6] It has been even less common for the neurologic symptoms to precede the diagnosis of sarcoidosis (Table 1). Although cranial and peripheral nerves are said to be most commonly affected with sarcoidosis, our cases illustrate involvement along the entire neuraxis.[7]

Case reports

Case 1. A 51-year-old white female was seen initially at our clinic in March 1975 with complaints of shortness of breath, productive cough, progressive muscular weakness, eye pain, and depression for several months. Her medical history included myasthenia gravis since 1960. At that time she had asymmetric ptosis, intermittent diplopia, difficulty chewing and swallowing, and limb weakness with exertion. All of her symptoms were improved with edrophonium chloride administration. Electromyographic (EMG) studies also had shown characteristic decremental response to tetanic stimulation. Pyridostigmine bromide therapy had controlled her myasthenia gravis up until the previous two months.

Physical examination showed bilateral sibilant, coarse rales in the lungs, and general motor weakness, proximally and distally, without focal wasting or fasciculations. Ophthalmologic examination showed slight orbicularis weakness, punctate staining of the cornea, filamentous keratopathy, and a Schirmer's test of less than 2 mm tear migration in 5 minutes. Laboratory studies revealed anemia, an elevated erythrocyte sedimentation rate (ESR) and elevated gammaglobulins. A chest roentgenogram showed hilar adenopathy. The vital capacity was 60 percent of predicted, the FEF_{25-75} 1.3 liter/sec (40 percent of normal), and diffusing capacity slightly less than predicted. A scalene node biopsy showed noncaseating granulomata. Tuberculin skin tests and cultures of the node were negative. The patient was treated with prednisone, 60 mg, daily.

The shortness of breath, wheezing, cough, and weakness rapidly disappeared, but eye pain, blurring vision, feelings of depression, and an iron-deficiency anemia occurred and she was readmitted to the hospital in July 1975. At that time she had a large antral ulcer and continuing problems with keratoconjunctivitis sicca. Her chest roentgenogram was normal. Prompt improvement of the ulcer followed antacid therapy and discontinuation of prednisone. When last seen in the clinic in December 1975, her myasthenic symptoms were absent.

Case 2. A 64-year-old white female was referred to the hospital in June 1975 for evaluation of progressive leg weakness and bilateral facial weakness of two weeks duration. Physical examination revealed decreased corneal reflexes, facial diplegia, bilaterally absent reflexes, and generalized muscle weakness.

Laboratory studies included cerebrospinal fluid protein of 160 mg/100 ml with no white blood cells present. An electroencephalogram showed diffuse, nonspecific abnormalities consistent with cortical and subcortical encephalopathy. The initial chest roentgenogram was within normal limits.

The patient became progressively weaker, confused, and aphasic. Twenty days after admission, a repeat chest roentgenogram showed hilar prominence. Tomograms confirmed lymphadenopathy and a scalene node biopsy showed noncaseating granulomata. Skin tests for histoplasmosis, coccidioidomycosis, and tuberculosis (intermediate PPD) were negative. The culture of the lymph node was negative for mycobacteria after six weeks. Pulmonary function tests showed 85 percent of predicted vital capacity and FEF_{25-75} was 1.81/sec or 65 percent of predicted.

Table 1—Nervous system involvement with sarcoidosis

Author	*Year*	*Location*	*No of Cases*	*Nervous System Involvement %*	*Nervous System Presentation %*
Mayock[1]	(1961)	Review of literature	625	5	—
Siltzbach[2]	(1967)	New York New York	311	4	1.2
Wiederholt[3]	(1967)	Rochester Minnesota	807	3.5	2.5
James[4]	(1970)	London England	537	7	—
Turiaf[5]	(1971)	Paris France	329	4	—

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Because of her deteriorating condition, prednisone, 100 mg, was given daily for three days, then reduced to every other day. She responded rapidly and she was discharged from the hospital 30 days after admission. Her discharge diagnosis was acute polyradiculoneuropathy (Guillain-Barré syndrome) and sarcoidosis. Her reflexes have returned to normal and her weakness has disappeared. The steroids were tapered gradually and discontinued six months later.

Case 3. A 57-year-old white female was admitted to the hospital in July 1975 for evaluation of recent 20 lb weight loss and a "lump in her neck." Her history included right eyelid ptosis and bilateral external ophthalmoplegia for approximately ten years. Two edrophonium chloride tests and a pneumoencephalogram had been normal during that time. In 1974 EMG and CPK tests suggested myopathy.

Physical examination upon admission revealed bilateral ptosis, lateral and upward gaze paralysis, and supraclavicular and cervical lymphadenopathy. Laboratory studies included an ESR of 31 mm/hr, a CPK of 223 IU, an aldolase of 4 units/ml, and a negative urine myoglobin. A chest roentgenogram showed a superior mediastinal mass. Scalene node biopsy revealed noncaseating granulomata with no organisms seen and negative AFB cultures of the node at six weeks. Mediastinoscopy and mediastinal node biopsies confirmed the diagnosis of sarcoidosis. Pulmonary function studies were normal. A repeat EMG revealed myopathic muscle potential. Sural nerve and gastrocnemius muscle biopsies showed active neuromyopathy without granulomata. The tissue was further thought to contain features of oculocraniosomatic neuromuscular disease with "ragged-red" fibers. The patient has not been treated with steroids. The patient's ophthalmoplegia has remained stable and a chest roentgenogram one year later showed no evidence of adenopathy.

Discussion

There was no direct evidence of sarcoid invasion of the involved tissue in the patients presented in this report. However, it is important to consider that sarcoid can cause neurologic disease. The most common neurologic manifestation of sarcoidosis is cranial nerve involvement. The facial nerve is most often affected, the acoustic and optic nerves are often involved. Wiederholt and Siekert[3] reported that 18 of their 28 patients with neurologic abnormalities and sarcoidosis had cranial nerve involvement. Other reported manifestations in their series included corticospinal tract signs, cerebellar signs, seizures, diabetes insipidus, peripheral neuropathy, and anterior pituitary insufficiency. Two of their cases had myopathy, one of whom had no evidence of granulomas in the muscle biopsy. Douglas and Maloney[6] differentiate between the neuropathies of cranial and peripheral nerves, and central nervous system involvement. They found only six cases of central nervous system (CNS) involvement in over 500 cases of sarcoidosis in the Edinburgh, Scotland registry.

The concomitant finding of myasthenia gravis and sarcoidosis has been reported only three times in the literature, two cases from the United States and one from France.[7-9] In all cases, the myasthenia gravis preexisted for several years before the onset or discovery of sarcoidosis. One of the patients responded well to steroids, one was asymptomatic, and the third was said to have been well after thymectomy. There is only one case report in the literature of associated Landry-Guillain-Barré syndrome with sarcoidosis.[10] The patient responded well to steroid therapy after establishment of the diagnosis.

Oculocraniosomatic neuromuscular disease with "ragged-red" fibers has only recently been described by Olson *et al.*[11] The disease is characterized by progressive external ophthalmoplegia and limb muscle biopsies showing pathologic fibers with mitochondrial clusters and an abnormal amount of lipid droplets ("ragged-red fibers").

Although we report this association between these neurologic syndromes and sarcoidosis, we are uncertain about the nature of this relationship. The temporal association suggests that the neurologic disease occurred independently in each case without evidence of sarcoid present at their onset. In two cases treatment with prednisone improved both diseases. In these two patients with myasthenia gravis and Guillain-Barré syndrome, an immunologic disorder had long been suspected. We speculate that in such cases, a common underlying immunologic disturbance may well influence the occurrence of sarcoid with these syndromes. The association of sarcoid with the oculocraniosomatic myopathy is obscure and may be fortuitous.

Hopefully, this report will encourage clinicians to consider the diagnosis of sarcoidosis in patients with neurologic disease, even though the deficits are not those traditionally thought to be associated with sarcoid. The short period in which these three patients presented to us suggests that the association is more common than generally accepted.

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Anticonvulsant drugs and rickets in children

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SEVERE RICKETS is uncommon in this country. Reports first from Europe and recently from the United States have reported osteomalacia associated with anticonvulsant drug therapy.[1,2,3] Several recent studies report that Vitamin D metabolism or catabolism is effected by certain anticonvulsants, particularly phenobarbital and diphenylhydantoin (phenytoin, Dilantin®).[4]

It is the purpose of this paper to emphasize that homebound or institutionalized children who are on anticonvulsants may develop unsuspected severe rickets. It is our feeling that, as in the case described, this is a result of two factors: (1) inadequate vitamin D intake plus (2) some additional effect on vitamin D by anticonvulsants.

The patient at increased risk is the bedridden or institutionalized child whose vitamin D intake or exposure to sunshine is low. The question of prophylactic vitamin D administration for patients will be discussed.

Case report

An 8-year-old boy who has had cerebral palsy and seizures since infancy developed joint deformities.

Delivery was said to have been followed by difficulty in resuscitation. On the second day of life the child reportedly had a convulsion. He was kept in an incubator for the first 10 days and received unknown amounts of oxygen for this period. Very little information could be obtained. At approximately six months of age the infant developed typical hypsarrhythmia. At the age of eight months an abnormal electroencephalogram was reported and the infant was started on phenobarbital. During the next few years the boy was extensively studied at two university medical centers and diagnoses of hypsarrhythmia, microcephaly and severe psychomotor retardation were made. Severe spastic quadriplegia developed.

From infancy to the present the child has received anticonvulsants continuously. In addition to phenobarbital, phenytoin (Dilantin®), primidone (Mysoline®) and ACTH were all tried in various dosage schedules without great benefit. Since phenobarbital and Mysoline® seemed most effective, these two medications were used almost continuously. Serum levels in early years were not available. Currently the boy is being followed at our clinic and levels are regularly monitored.

The family has desired to provide care in their farm home for this totally bedridden child. The mother believes he was given vitamins the first year of life, but had been given no vitamin supplements to his diet since. The boy received raw milk and seldom was taken out into the sunshine.

In May 1975 the boy was seen for a minor illness and joint enlargement of the knees and a severe genu valgum not previously observed was noted. Wrist deformities were also obvious as were previously known extensive deformities associated with the cerebral palsy. Orthopedic consultation was held. X-ray films showed osteoporosis and severe rachitic changes (Fig 1). Extensive testing was done by a urologist to rule out any form of renal rickets; all tests were within normal limits.

Laboratory values were as follows: calcium 8.8 mg/dl (normal 8.5-10.5 mg/dl; serum phosphorus 2.7 mg/dl (normal 2.4-4.7); serum alkaline phosphatase 297 IU; hemoglobin 12.8 gm/dl; serum sodium 142 mEq/liter; potassium 4.4 mEq/liter.

Figure 1—Active rickets. Note the poorly calcified, frayed metaphyses and coarse trabecular pattern. There are fractures of the distal epiphyses of the radius and ulna.

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Figure 2—Right knee showing non-treated rickets. Note wide metaphyses, osteoporosis, coarse trabeculation with poorly mineralized and widened physis.

Figure 3—Healing rickets six months after treatment. Less osteoporosis, healing fractures of distal radius and ulna.

Figure 4—Healing rickets in knees.

A diagnosis of severe rickets was made and the child was started on 500 units of vitamin D-2 (Drisdol®) daily. After one month the patient was reevaluated. There was no x-ray evidence of healing.

Consultation was held with Dr Sara Arnaud of the Mayo Clinic. Serum sent to her laboratory revealed a severe hyperparathyroidism, probably secondary to the long-standing calcium and vitamin D deficiencies. The dose of vitamin D-2 was increased to 5,000 units per day for one week and then 1.200 units daily for one month. There was a marked improvement in blood values and in the x-ray appearance, as healing took place.

Date	*25-OH Vit. D*	*Parathyroid Hormone*	*Ca*	*Mg*	*P*
6/18/75	Undetectable	230 microliter equiv/ml	8.5 mg/ml	2.05 mg/ml	2.7 mg/ml
9/4/75	Over 40 ng/ml	30 microliter equiv/ml	9.0 mg/ml	2.10 mg/ml	5.2 mg/ml

Current concepts of vitamin D metabolism

There are two related fat soluble substances that can prevent rickets, vitamin D-2 (calciferol) and vitamin D-3 (cholecalciferol).

Ergosterol $\xrightarrow{\text{irradiated}}$ calciferol (vitamin D-2).
(found in plants)

Calciferol is the active constituent in most commercial vitamin preparations such as viosterol, irradiated yeast and irradiated bread.

In animals including humans the following takes place:

cholesterol ——→ 7, dehydrocholesterol
intestinal mucosa

transported to skin
——→ cholecalciferol (Vitamin D_3)
activated by ultra violet (sunshine)

than activated by ultraviolet of sunshine ——→ cholecalciferol (vitamin D-3). Vitamin D-3 is the form found in irradiated milk and fish liver oils. In man (vs animals) both vitamin D-2 and D-3 are equal in activity and effectiveness.[10]

Cholecalciferol is not the "anti-rachitic" active principal, as once thought, but enters into a complex cycle to become the active factor, 1,25 dihydroxycholecalciferol. Cholecalciferol is changed within the liver to 25-hydroxycholecalciferol, then in the kidney another hydroxyl ion is added to produce 1,25 dihydroxy vitamin D, the principal active metabolite.[11]

Cholecalciferol
↓ Liver
25-OH Cholecalciferol —→ Inactive Metabolites
(25-OH Vitamin D)
↓ Kidney
1,25 Dihydroxylcholecalciferol —→ Inactive metabolites
(1,25 [OH] 2 Vitamin D)

+ Parathyroid Hormone
Acts on bone metabolism
Acts on renal tubular transport of phosphates
Acts on intestinal mucosal transport of calcium, phosphorus

Metabolic Pathways of Vitamin D (modified from Harrison and Harrison[11]).

Anticonvulsant drug effects on vitamin D metabolism

Rickets and hypocalcemia were reported in 15 percent of a German pediatric outpatient epileptic population studied by Kruse in 1968, a review by Hahn notes.[1] British reports recorded hypocalcemia in institutionalized epileptic adults and children receiving long-term anticonvulsant therapy in 1970 and 1971.[2,3] In the United States research studies by Richens and Rowe, Hahn and others demonstrated that the administration of anticonvulsant drugs, particularly combinations of phenytoin (diphenylhydantoin, Dilantin®) and phenobarbital is associated with a decrease in 25-hydroxycholecalciferol.[4,5,6,7] This is believed to be due to the induction of liver microsomal enzymes which change 25-hydroxycholecalciferol (25-OH vitamin D) and 1,25 dihydrocholecalciferol (1,25 [OH]2 vitamin D) to inactive metabolites which combine with glucuronic acid and are excreted in the bile and urine.[8]

The work of Dr T J Hahn of St Louis is of particular interest. He demonstrated that chronic anticonvulsant therapy decreased the plasma half-life of intravenously given vitamin D.[9] In rats phenobarbital increased liver microsomal conversion of vitamin D and increased polar metabolites different from the known active vitamin D metabolites.[1] Hahn studied adult populations receiving long-term anticonvulsant therapy compared with matched controls and found reductions in serum calcium and 25-hydroxycholecalciferol more marked when both phenytoin and phenobarbital were given than when only one was used.[1] Most observers now feel that anticonvulsants can to some extent increase the catabolism of vitamin D, diverting some of the vitamin D from its normal primary cycle. This alone is probably not enough to produce rickets but may be a contributory factor when vitamin D intake or sunshine exposure is inadequate in a child.[8]

Detection

Severe rickets is easily detected by bone deformity. The detection of mild vitamin D deficiencies is not so easy. Osteomalacia is characterized by hypocalcemia, hypophosphatemia, elevated serum alkaline phosphatase and changes in the x-ray appearance of bone. These methods have limitations, however. For example, routine x-rays detect decreased bone density only after a 30 to 50 percent reduction in bone mass has taken place.[12] Fortunately newer more accurate methods for detection are becoming available. These include measurement of serum 25 hydroxycholecalciferol, serum alkaline phosphatase isoenzyme levels and bone mass measurement by the photon absorption technique (Norland-Cameron Bone Mineral Analyzer made by Norland Instrument Company, Fort Atkinson, Wisconsin).[12] Serum calcium, phosphorus and 24-hour urinary calcium excretion tests are standard and useful tests.

Incidence

Varying incidences of vitamin D disturbances or rickets have been reported, partly depending on the tests used for detection and their interpretation. The incidence of hypocalcemia and x-ray evidence of rickets in institutionalized subjects receiving anticonvulsants has ranged from 10 to 30 percent in different series.[8] Leonidas in the radiology literature in 1973 described six patients with rickets felt to be due to anticonvulsants.[13] Of 289 severely retarded inpatients at a school for retarded children in Utah, 67 were found to have osteomalacia; all 67 were receiving phenytoin (Dilantin®) or phenobarbital or both. One control group comparison has recently been reported.[12] Significant reductions in serum 25 hydroxycalciferol and bone mass occurred in 56 epileptic children re-

ceiving chronic anticonvulsant medication compared to 51 controls.[12]

The role of anticonvulsant drugs in producing rickets is questioned by some. Livingston et al, using skull x-ray films, serum calcium phosphorous and alkaline phosphatase among their initial evaluation studies, have not found chemical or clinical evidence of osteomalacia or rickets in any of 15,000 patients seen over a 36-year period at their Epilepsy Clinic at Johns Hopkins Hospital.[15] Recent reviewers seem to feel that anticonvulsants probably do have some effect on vitamin D and calcium metabolism in the body and that newer more refined tests may well be detecting subtle abnormalities not previously detected.[8,16]

Other anticonvulsants than Dilantin® and phenobarbital may cause similar effects but thus far have not been so frequently suspected. Many anticonvulsants, glutethimide, and many tranquilizers are known to be capable of inducing liver microsomal enzyme activity that affects the catabolism of several steroid hormones whose structures are similar to vitamin D metabolites.[1] Significant loss of bone mass has recently been noted in diabetics.[17]

Treatment

This must certainly be individualized for severity, drug type and dose, physical activity level, sunshine, race, and response. Hahn recommends 100,000 units of vitamin D per square meter per week for two to six months with monthly monitoring and then a prophylactic dose of 5,000 to 15,000 IU of vitamin D/m^2/week.[1]

Discussion

A result of interest in the case presented was that the serum calcium level was normal. This is in agreement with other reports of children. In Hahn's controlled series, only 2 of 50 anticonvulsant treated children had low serum calcium values, probably due to an ability of children to mobilize bone calcium by action of parathyroid hormone responding to decreased vitamin D levels.[12] This emphasizes the need for very careful testing preferably using 25 hydroxycalciferol assays or photon absorption tests on bone. The latter has a sensitivity of 4 percent accuracy of estimation of bone mass.[12]

Comment

In Wisconsin at Central Colony, a large state facility for many types of severely brain-damaged residents, all children to the age of seven or eight years are given daily vitamins. Fortified milk is used and sunshine exposure is frequent. Dr John Toussaint reports that although 500 of 850 residents require anticonvulsants (mostly Dilantin®, phenobarbital or Mysoline®) rickets has almost never been seen. Only four or five cases have been seen in the past 16 years.[18]

Tolman et al[14] have stated that the single most costly medical problem at their hospital for severely retarded is the treatment of pathologic bone fractures due to demineralized bone.

Prophylactic vitamin D for patients receiving long-term anticonvulsant therapy has been felt to be unnecessary by Livingston[15] and questioned by others[19] but recent studies showing reduction in bone mass in ambulatory outpatient children treated for prolonged periods with anticonvulsants suggest an increased need.[12]

Conclusions

There is an increased need, although not a great one, for vitamin D in children who receive long-term anticonvulsants, particularly phenytoin (Dilantin®) and phenobarbital. This is probably due to increased catabolism of vitamin D due to drugs. At risk of developing osteomalacia or even rickets is the child on prolonged medication with inadequate exposure to sunlight, poor nutrition, and inactivity. Such a child may be found in an institution or as in the case described in a home where vitamin D, fortified milk or sun exposure were below average.

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Transplantation for end-stage renal disease in children in Wisconsin

Consecutive cases since 1974

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ALTHOUGH RENAL allotransplantation has been an accepted form of therapy in adults with end-stage renal disease for almost two decades, its use in uremic children has only recently achieved wide acceptance.[1,2,3] Despite the demonstration of successful transplantation in children as early as 1966,[4] most have taken place since 1970.[5] Fine and Grushkin have noted that more than 500 renal transplants have been performed in patients under 19 years of age.[5] Our aim is to describe our experience with childhood transplantation since April 1974 and to emphasize that children with uremia can benefit from this form of therapy. A case will also be presented in more detail as an illustration.

Case report

The patient, born in 1967, had a right flank mass at age six months. A right nephrectomy was performed. Histologic examinations of renal tissue disclosed a Wilms tumor. The patient underwent radiotherapy and was healthy until age seven when he sustained a fracture of his remaining kidney in a bicycle accident. Moreover, an avulsion of the ureter from the renal pelvis resulted in drainage and dissection of urine into the left flank. Two attempts at a plastic repair and an autotransplantation of his kidney into the right iliac fossa did not preserve renal function. A femoral artery to saphenous vein shunt was created and he was started on hemodialysis three times a week for three months.

In June 1975, eight months after the accident and three months after nephrectomy, he received a renal transplant from his mother. The transplantation procedure and postoperative period were uneventful except for a mild rejection episode which rapidly reversed.

Six months after transplantation, he was placed on alternate-day prednisone and has grown two and three-quarter inches in the past 12 months. At present he has normal renal function (serum creatinine concentration of 0.7 mg/dl) and is attending school regularly.

Results

Between April 1974 and January 1977, 15 children less than 19 years of age have received a total of 16 transplants at our hospital. There have been no deaths and only one child has required a transplant nephrectomy with a return to hemodialysis. Two patients initially received cadaveric transplants and the remaining patients utilized living related donor grafts. One patient, who received a transplant from her father, has been transplanted a second time with a cadaveric transplant. Pertinent clinical features of these patients are listed in Table 1. Seventy-five percent (12 of 15) of patients now have creatinine under 2.5 with 67 percent (10 of 15) of the children under 1.6 mg/dl.

Only three of these patients had a form of chronic glomerulonephritis; the remaining 12 patients had a congenital or hereditary form of renal disease accounting for their chronic renal failure. Two patients required transurethral resection of posterior urethral valves before bladder function was adequate. Eleven of the patients were adolescents at the time of transplantation.

Three of the patients received their grafts after epiphyseal fusion had taken place. Seven other transplant recipients were transplanted within the past eight months and have not been on alternate-day steroid therapy or low-dose daily therapy for any extended period. However, five patients have been followed for a long enough period to allow comment concerning their linear growth.

As shown in Table 2, three of the five patients are adolescents and close to the end of their growth period. Although these three (Patients 1,3, and 4) did not grow after transplantation, they remain at the third percentile or below. The two remaining patients are not adolescents and one (Patient 6) has shown catch-up growth such that he is now at approximately the tenth percentile. The other child (Patient 2) grew after transplant but then developed chronic rejection requiring increased daily steroid therapy.

Discussion

Physicians have tended to avoid transplantation in children largely because of technical difficulties and the size of the patient. However, with these problems overcome except in the smallest children, the current major pitfalls in renal transplantation are various medical complications.

Growth is the unique province of children. Concern was voiced early that the medication required to prevent rejection would lead to growth retardation, a condition already prevalent in children with chronic renal failure. It was hoped that the return of kidney function by transplantation would permit accelerated growth provided epiphyseal fusion had not occurred.

Corticosteroid therapy, a known cause of growth retardation, has

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Table 1—Clinical features of children receiving renal transplants

Patient Number	*Transplant Number*	*Sex*	*Date of Transplant*	*Age at Transplant*	*Donor Relationship*	*Recent Serum Creatinine mg/dl*	*Diagnosis*
1	1	F	4-74	14	Father	2.1	Medullary cystic disease
	2		2-75	15	Cadaver		
2	1	M	11-74	9	Mother	4.6	Posterior urethral valves and hydronephrosis
3	1	F	11-74	13	Father	1.3	Left hypoplasia and right aplasia
4	1	M	1-75	15	Mother	1.5	Interstitial nephritis
5	1	M	3-75	19	Brother	1.2	Membranoproliferative glomerulonephritis
6	1	M	6-75	7	Mother	0.7	Wilm's tumor and trauma
7	1	F	7-75	17	Cadaver	0.9	Interstitial nephritis with reflux
8	1	F	3-76	14	Sister	1.1	Rapidly progressive glomerulonephritis
9	1	M	4-76	14	Sister	7.9	Alport's syndrome
10	1	M	6-76	7	Cadaver	dialysis	*Focal sclerosing glomerulonephritis
11	1	F	7-76	12	Mother	1.1	Hypoplasia
12	1	F	11-76	18	Mother	1.0	Membranoproliferative glomerulonephritis
13	1	F	11-76	13	Mother	2.1	Hypoplasia
14	1	M	1-77	3	Mother	0.5	Posterior urethral valves
15	1	F	1-77	16	Sister	1.0	Interstitial nephritis with reflux

*Patient on hemodialysis with nephrectomy

been shown to prevent normal growth in transplanted children when used in a daily dose schedule.[6] Recently a number of centers have switched to alternate-day corticosteroid therapy and at least two reports document improved growth and catch-up growth using the alternate-day steroid regimen.[7,8] Our experience with a small number of patients over a short period does not allow for any major conclusions. We remain hopeful that transplantation with low-dose and alternate-day steroid therapy will allow for more normal growth as demonstrated by the case report.

Table 2

Patient number	*Present age*	*Months since transplant*	*Growth in cm since transplant*	*Present growth percentile*
1	17	22	5	3
2	11	25	3.8	3
3	15	25	5	3
4	17	23	2	3
6	9	18	6.3	10

Another problem most likely related to corticosteroid therapy is orthopedic complications.[9] The most common complication is aseptic necrosis of the femoral head or condyle. Other complications involving bone include nontraumatic stress fractures, slipped capital femoral epiphyses, and atrophy of the femoral head. It should be noted, however, that orthopedic difficulties are more common in adults than children.[9] We have not experienced any orthopedic complications since initiating the use of low-dose immunosuppression.

Finally, concern had been raised about how immunosuppressive agents would affect sexual maturation. All available evidence points to normal development.[4] Adolescent females who were pubertal but amenorrheic pretransplant began to menstruate soon after transplantation.[10] Male recipients have fathered normal children and female transplant patients have given birth to normal children.[11]

Conclusion

End-stage renal disease is very distressing to the child, the family, and the physician. Dialysis is often difficult in children, both technically and psychologically. The various medical problems such as weakness, malaise, nausea, and shortness of stature decreases the quality of life for the child with chronic renal failure. Renal transplantation offers a form of therapy that may be curative and can result in a much more normal lifestyle. As demonstrated by our series as well as others, the recent success of transplantation in childhood warrants its

A team approach to continuous epidural analgesia in obstetrics

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CONTINUOUS EPIDURAL analgesia is considered by most obstetricians and anesthesiologists as nearly the ideal obstetrical anesthetic method. It provides selective blockade of the specific pain pathways involved in each stage of labor. There is minimal transference of anesthetic agents into the neonatal circulation. Because the mother is awake —and generally unsedated—it reduces the possibility of regurgitation and aspiration, which is the leading cause of maternal mortality; and it provides a comfortable mother who can experience and enjoy the process of childbirth.

Unfortunately, only a small number of mothers are able to avail themselves of this Cadillac of obstetrical anesthetics. Few anesthesiologists are found in the labor and delivery suites. This may be due to a lack of emphasis of this part of anesthesia in the usual training program or to the desire not to be limited to a relatively specialized field. Probably of greater importance is the simple economic fact that a large volume of deliveries is necessary in order to pay for 24-hour, 7-day coverage in the obstetrical department. This of necessity limits the availability of epidural analgesia on a continuing basis to the very largest, specialized obstetrical centers. Most anesthesiologists cannot find time in a busy operating room schedule for time-consuming, unscheduled, "one-on-one" obstetrical coverage.

Over the past five years, our hospital, a small suburban institution, has been able to overcome this economic bar to better obstetrical anesthesia by the development of a team approach to the problem.

Essentially, the team consists of the anesthesiologist, the nurse anesthetist, the labor and delivery nurse, and the obstetrician. The anesthesiologist supervises the team and performs the technical aspects of needle and catheter placement. Although not remaining at the bedside, he follows the patient throughout labor and delivery, determines dosage of reinjection and changes anesthetic plans as appropriate.

The nurse anesthetist reinjects the epidural catheter as necessary on the orders of the anesthesiologist and monitors the patient during the post-injection period for complications and reactions. He also does a pre-anesthetic history and starts intravenous fluid therapy.

The labor and delivery room nurse is responsible for the general observation of the patient, both from the obstetrical and the anesthetic standpoint, particularly in regard to blood pressure changes. The obstetrician supervises the obstetrical management of these patients and is responsible for the selection and prenatal orientation of

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TRANSPLANTATION . . .

consideration in all children with end-stage renal disease.

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patients for epidural anesthesia. A pediatrician is available if necessary. Continuous fetal heart tone monitoring is routinely employed.

The team members are intensively trained and oriented not only in their own particular roles but also to recognize untoward anesthetic and obstetrical reactions occurring at any time and to immediately respond with appropriate measures. An on-going training program is in effect.

This approach provides continuous care to the patient by skilled personnel with an anesthetic technique not otherwise available. At the same time, it frees the anesthesiologist from a time-consuming and expensive "one-on-one" relationship so that he can be available for other tasks within the hospital. The enthusiasm and skills of the nurse anesthetist are enchanced by bringing him into an area not ordinarily considered his. The labor and delivery nurses get a new perspective on obstetrical problems. Overall, the patient benefits.

Informed consent of the patient begins during prenatal discussions with the obstetrician and is supplemented with a printed pamphlet distributed by the labor and delivery nurses and orally confirmed by the anesthesiologist at the time of institution of the block.

Our experience has shown that this team approach not only has improved all facets of obstetrical anesthesia but also has resulted in a closer harmony and appreciation by all members of the team.

The technique of continuous epidural block is adequately covered in standard text books and will not be described. On our service, the block is established when the patient becomes moderately uncomfortable and the cervix is dilated approximately 4 to 5 cm for multipara and about 6 cm for the primiparous. An attempt is made in each instance to pass a polyethylene catheter into the epidural space through the needle for subsequent reinjection. Persistent paresthesias, blood return or inadvertent dural puncture dictate replacement of the needle at an adjoining interspace.

Our agent of choice is bupivacaine 0.25% because of its minimal motor effect and very low level of transference to the fetal circulation. However, because of the slow onset of this agent, lidocaine 1.5% or chloroprocaine 2% was used in a few instances for reinjections at the time of delivery.

A total of 200 patients received continuous epidural analgesia over a 13-month period ending June 30, 1976. Eighty-nine of these were primiparous; the remainder ranged in parity up to eight. In two patients a block was unable to be established and in one instance reinjection of the epidural catheter was impossible. Two of these patients were subsequently delivered under light general anesthesia; the third had a pudendal block. Persistent paresthesias were encountered in two patients and a bloody tap in one. In both of these cases, the catheter was successfully placed at an adjoining interspace.

The initial injection was sufficient for the duration of labor in 60 patients (30%). The remaining patients received up to three injections. There was no apparent significant increase in the duration of labor. Forceps delivery was used in 121 patients (60%).

Analgesia was supplemented at the time of delivery in 45 (22.5%) patients by means of pudendal block or local infiltration. This usually was because of a rapidly progressing second stage of labor or fetal distress necessitating rapid delivery.

Four patients came to cesarean section during this series due to cephalopelvic disproportion. Two of these patients were operated under an extended epidural block; the remaining two were converted to general anesthesia.

Table 1—Apgar scores

	1 Min	*5 Min*
10	5	150
9	143	43
8	38	4
7	5	2
6	5	1
<6	4	0
	200	200

Inadvertent dural puncture occurred four times (2%). In all cases the epidural catheter was successfully replaced in an adjoining interspace. Two of these developed headaches, one requiring an epidural blood patch. The other two patients had 20 ml of normal saline injected prophylactically via the epidural catheter at the conclusion of delivery.

Possible local anesthetic reactions were seen in two patients. Both of these had transient periods of "shakiness and chills." One had minimal cyanosis associated with evidence of fetal distress. The supine hypotensive syndrome, due to sympathetic blockade of the lower extremities and the pressure of the gravid uterus, was seen in only two patients. We feel that this low incidence was due to our policy of routinely utilizing a fluid load and left uterine displacement.

Evidence of fetal distress was seen nine times (4.5%). Four were associated with a cord around the neck and two with cephalopelvic disproportion, and one each with a possible local anesthetic reaction and maternal hypotension. Apgar scores for the series are recorded on the accompanying table. The nurse anesthetist was in attendance at delivery in 50 of the procedures.

The team concept of continuous epidural analgesia was well accepted by our obstetricians, nurses, and patients. A high level of enthusiasm was evident.

Summary

Utilizing a team of professionals for continuous epidural analgesia for obstetrics has resulted in: (1) provision of quality anesthesia care in the small community hospital; (2) freeing the anesthesiologists from continuous attendance at the labor bedside in order to accomplish other duties, and (3) increased utilization of skills, training, and time of the nursing personnel. ■

Postmaturity syndrome —A pediatrician's view

Richard D Zachman, MD, Madison, Wisconsin

IN THE JULY 1977 ISSUE of the **Wisconsin Medical Journal** we summarized the experience at the Wisconsin Perinatal Center in Madison in the management of post dates pregnancies with an emphasis on maternal and fetal diagnostic and therapeutic approaches. The present article complements the previous one in providing recommendations for the care of the post dates neonate.

THE NEONATE BORN after a post term pregnancy frequently has problems related to postmaturity. The relative degree of placental insufficiency associated with postmaturity allows the pediatrician to anticipate a number of neonatal problems such as asphyxia, meconium aspiration, growth retardation, hypoglycemia, polycythemia, and persistence of fetal circulation.

The physical characteristics of the postmature baby are often clear. They include a dry, cracked and crumbled skin, a malnourished appearance with long, thin body and frequently meconium staining of the skin and long nails. Although this syndrome is well recognized, it has not been the subject of as much recent interest or research as other neonatal problems. Because of the significant morbidity encountered in these babies, this article outlines some approaches that might be useful to those caring for the postmature neonate.

1. Asphyxia neonatorum

The principles of resuscitation are as always—keep the baby warm, establish an airway, stimulate to cry; if no improvement, use face oxygen or positive pressure oxygen if the heart rate is less than 100 or there are no spontaneous respirations. Intubation, cardiac massage, and metabolic resuscitation may be necessary in severe asphyxia.

2. Meconium aspiration

Modern treatment of meconium aspiration calls for a more aggressive approach than many of us are used to. "All infants born through thick, particulate or pea soup meconium should have their trachea aspirated immediately after birth," states a well known pediatric anesthesiologist. The most recent and recommended approach is for the obstetrician or an assistant at delivery to suck the oral and nasal pharynx with a suction catheter as soon as the head of a meconium-stained infant is delivered. After complete birth of the baby, the vocal cords are visualized by direct laryngoscopy and the trachea is sucked out.

3. Intrauterine growth retardation and hypoglycemia

Placental insufficiency *in utero* can lead to poor fetal nutrition. Poor fetal nutrition in turn would cause the fetus and neonate to have poor energy stores in the form of subcutaneous fat depots or liver glycogen. At birth then, the intrauterine growth retarded neonate is highly susceptible to neonatal hypoglycemia. Monitoring the postmature infant's blood sugar frequently by the use of Dextrostix® is suggested. An approach to the treatment of this baby would be early feedings (even at 1-2 hours of life) if there is laboratory evidence of hypoglycemia, and the use of frequent feedings. Intravenous glucose may be necessary if the baby cannot tolerate nipple or nasogastric feedings.

4. Polycythemia

Intrauterine hypoxia can stimulate fetal erythropoietin synthesis which is followed by increased synthesis of red cells and polycythemia. Polycythemia can cause increased blood viscosity and sluggish circulation in the neonate which can be associated with cyanosis, hypoglycemia, oliguria, persistent jaundice, and central nervous system symptoms. If a neonate is symptomatic from polycythemia (central hematocrit $>65\%$), one should consider a partial exchange transfusion with fresh frozen plasma. The objective of this partial exchange is to lower the hematocrit to $<55\%$ so that blood flow is improved. Mere phlebotomy is not recommended for the neonate since it might cause hypotension and shock.

5. Persistence of fetal circulation

This is a recently described entity. The major problem is pulmonary vascular vasospasm, causing blood to shunt right to left through the foramen ovale and patent ductus arteriosus. The result in the neonate is profound hypoxia and acido-

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■ SUPPORTED BY THE WISCONSIN PERINATAL CENTER, SOUTHCENTRAL REGION, MADISON

sis. As fast as possible the inspired oxygen concentration must be increased. If there is no improvement in the infant's condition, experimental drugs that dilate the pulmonary vasculature and assisted ventilation may be necessary.

Postmaturity can be a neonatal disaster. Much mortality and morbidity associated with the postmature neonate can be prevented by good perinatal awareness of the problem and helping the neonate adapt to extrauterine life. A person experienced in neonatal resuscitation should attend all postmature deliveries. Good resuscitation and suctioning meconium from the trachea is frequently necessary in postmature births.

Intrauterine growth retardation must be recognized and should be accompanied by frequent monitoring of blood glucose and early intervention if neonatal hypoglycemia occurs. A hematocrit evaluation is recommended on postmature neonates to screen for polycythemia. Awarness of the possibility of hypoxia and acidosis from persistence of fetal circulation must be maintained because it is a life-threatening disease.

From a neonatologist's point of view, all post date pregnancies should be considered for referral to a facility where adequate prenatal and intrapartum assessment of fetal well-being can be made and where adequate neonatal support is available. ■

ABSTRACTS/ WISCONSIN AUTHORS

Papers presented before Wisconsin Neurological Society, May 13-14, 1977 in Oconomowoc
Francis M Forster, MD, Madison, WNS Secretary for Continuing Medical Education

Cysticercosis cerebri presenting as focal motor epilepsy

Thomas V Nowak, MD and Jerome V Murphy, MD, Milwaukee

This paper reported a 20-year-old Mexican female with right-sided focal seizure. No neurologic abnormalities were noted on admission. Skull x-rays demonstrated two left cerebral calcifications which were confirmed by computerized axial tomography. The serum cysticercosis titer (complement fixation) was positive at a 1:64 dilution. The patient was treated with anticonvulsant drugs and has remained asymptomatic.

Motor seizures, both focal and generalized, are a common presentation of cerebral cysticercosis. Seizures may occur either in the acute stage of the disease, or many years following the original infestation. In reports from other countries, cysticercosis cerebri was responsible for 25% of intracerebral masses and for 35% of all craniotomies. The three neurologic syndromes this disease produces are: (1) focal deficits and seizures secondary to a mass lesion, (2) non-focal increased intracranial pressure secondary to widespread intracranial cysts, and (3) fever and meningismus.

The diagnosis of cerebral cysticercosis is based on a history of living in an endemic area, radiologic evidence of characteristic intracranial calcification, peripheral eosinophilia, cerebrospinal fluid abnormalities, and a positive complement fixation test. As many former Mexican residents live throughout our state, this disease must be considered in the differential diagnosis of focal motor epilepsy in Mexican-Americans. ■

Congenital oculomotor apraxia; study of five cases: a retrospective

William W Orrison, MD; William C Robertson Jr, MD; and Richard E Appen, MD, Madison

In 1952 Cogan introduced the term congenital oculomotor apraxia to describe an abnormality of ocular movements characterized by absent or defective voluntary horizontal gaze. Since his original description, there have been few subsequent reports of this disorder. A ten-year review of clinical records from the University of Wisconsin Hospitals revealed ten patients with diagnoses compatible with oculomotor apraxia. Four of these ten patients met the clinical criteria for congenital oculomotor apraxia. A fifth previously undiagnosed case was discovered by screening in the Pediatric Neurology Clinic. Two patients were originally thought to be mentally retarded but recent Neuropsychological Testing has been within the normal range. The theoretical and practical implications of congenital oculomotor apraxia were discussed. ■

Familial paroxysmal movement disorder

David Goodenough, MD; Ruggero Fariella, MD; and Raymond WM Chun, MD, Madison

The usual movement disorders in children persist in the waking state, are thus readily noted on neurological examination, and may be exacerbated during periods of stress. They disappear, however, in sleep. Some movement disorders in children occur only paroxysmally and are therefore called paroxysmal choreoathetosis or periodic dystonia.

This paper presented three cases of familial paroxysmal movement disorder all having their onset in childhood. Anticonvulsant medications completely ameliorated the choreoathetotic and dystonic movement.

The paroxysmal movement disorder (PMD) can be classified into two distinct categories; familial and acquired. The former begins in childhood and can or cannot be induced by sudden movements (kinesigenic or non-kinesigenic form), has a benign course, and responds readily to anticonvulsants. It is likely due to some still unknown disturbance of the extrapyramidal motor system. The latter has a later onset and is an expression of an underlying neurologic or metabolic disease. Some cases of acquired PMD have particular forms of epilepsy. In these cases an EEG during an ictal episode may prove particularly significant. ■

Experience with laminar airflow in the management of major burns

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INFECTION IS THE most common cause of mortality in patients hospitalized after major thermal injury.[1] The burn patient is extremely susceptible to infection not only because of the presence of nonviable skin where bacteria colonize but also because of marked depression of white cells and reticulo-endothelial functions post-injury.[2] This severe immunosuppression may last for extended periods. Exogenous spread of hospital organisms to the burn victim is a common source of the septic complications. An attempt was made to diminish this type of infection by the construction of a four-bed horizontal laminar airflow isolation system to be used exclusively for the care of the severely burned patient at our hospital burn unit.

Laminar airflow is defined as airflow in which the entire mass of air within a confined space moves with uniform velocity along parallel flow lines. Because of the lack of turbulence, all particles or bacteria in the air are carried out of the clean area and filtered.[3] The rate of flow of 60 feet per minute, although nearly imperceptible, is much higher than the rate airborn particles settle. Pathogens are isolated in less than 1% of unit air cultures as opposed to 60% in hospital rooms. Special techniques, similar to those used in surgery, are also necessary for disinfecting all unit surfaces. Sterile gowns, caps, masks, gloves, and booties are worn at all times. All items, including food, entering the unit are decontaminated by special procedures.

The University of Wisconsin laminar flow unit (Fig 1) is one of only two such units in the country being used for the treatment of burns. The other laminar flow units in existence are primarily concerned with the treatment of cancer patients. One such unit at M. D. Anderson Hospital has reported a significant decrease in the incidence of infection.[4]

The University unit has been in operation since 1974. The burn team responsible for patient care includes physicians, nurses, nutritionists, and occupational and physcal therapists specially trained in burns and the principles of laminar flow. All patients at high risk for infection are admitted to the unit. This includes adults with greater than 20% or children greater than 15% deep body surface burns, burns in precarious areas such as hands, face, and perineum or evidence of inhalation injury. Minor

Figure 1—The University of Wisconsin laminar burn unit, shown above, is divided into two 2-bed compartments. The laminar flow panels are seen at the head of the beds with airflow directed out of the clean area to the nonclean area, which begins at the bottom of the photograph here.

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Table 1—University of Wisconsin laminar flow unit

% Total Burn	Mean % Burn	No.	Mean Age	Range	Deaths	Mortality Rate Actual	Mortality Rate Predicted*
0-20	13	21	26	1-67	0	0	2.2
21-35	32	26	27	1-80	2	7.7%	15.4
36-50	45	17	25	1-63	1	5.8%	36.5
51-65	60	11	31	1-62	3	27.2%	66.7
66-80	74	7	29	7-62	3	42.8%	87.7
81-100	90	3	47	7-62	3	100%	97.7
		85			12		

*Predicted rates from Stern and Waisbren[5]

Table 2—Burn deaths

No	Age	% Burn	Time post-burn	Cause
1	80	33	46 days	Respiratory failure
2	65	30	2 days	Inhalation injury
3	58	50	7 days	Inhalation sepsis
4	8 mo	60	15 days	Hyperosmolarity
5	9	90	14 days	Respiratory failure
6	62	80	4 days	Cardiac failure
7	49	51	10 days	Sepsis
8	32	70	14 days	Respiratory failure
9	7	70	6 mths	Massive aspiration
10	10	61	1 day	Inhalation injury
11	52	65	3 mths	Respiratory failure
12	70	90	2 hrs	Cardiac failure

burns are treated by the burn team under strict aseptic techniques in areas not under laminar flow.

We review here our experience, with particular reference to mortality and infectious complications.

Results

To date 84 patients, or about one-third of burn admissions, have been treated in the unit. Our results are shown in Table 1. Mortality rates for all groups of burns except those in the 90% category are much lower than predicted. The predicted rates are taken from tables devised by Stern and Waisbren from experience at St Mary's Hospital in Milwaukee.[5] The causes of death in our series are shown in Table 2. Only two deaths could be directly attributed to sepsis. Both these patients were transferred out of laminar flow to the intensive care unit for respiratory support. Burn infection then occurred. Currently the burn unit is equipped to maintain full respiratory support and transfer is no longer necessary. As shown in Table 2, patients with massive inhalation injury or the aged with near total burns are probably not benefited from laminar flow. Under these circumstances the cause of death is frequently not infection. The morbidity rate is difficult to estimate, but two points suggest a decrease. First, there has been no instance of cross contamination of infection between patients in the unit. Secondly, no organism resistant to standard antibiotics has been isolated.

Infection continues to be the leading cause of death in patients after major burns. Exogenous spread of resistant hospital organisms is often the source. Laminar airflow and isolation techniques have been shown to markedly decrease this spread of infection both in cancer patients and from our experience in burn patients. The near total body burn or the massive inhalation injury are probably not benefited by this technique because death is usually due to early cardiorespiratory failure. The patients most benefited are those with body burns in the range of 40% to 65%, where infection is usually the cause of death. With present day advances in cardiorespiratory and nutritional support, prevention of infection in this group will produce minimal mortality.

Conclusion

Although our numbers are too small to yield statistical significances, our low mortality figures, particularly for the 40% to 65% burn, suggests strongly the benefits of laminar airflow in treating the burn victim.

ACKNOWLEDGMENT: To the burn team for continued excellence in patient care.

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EDITOR'S NOTE: Readers of the above article also may be interested in the editorial, "Major burns," which appears in this issue on page 8. ■

To be aware of splenic rupture during pregnancy; case report

Werner A Hauschild, MD, Kenosha, Wisconsin

RUPTURE OF THE spleen was first described in 1803 and first treated surgically in 1898.[1] Spontaneous rupture of the spleen is in itself a diagnostic challenge. During pregnancy it may be even more masked. The dramatic event usually leaves very little time for diagnostic considerations, and two lives are at stake.

Case report

A 27-year-old nullipara, gravida II, 17 days to term, was admitted to the hospital after sudden onset of severe left-sided chest pain radiating to her left arm, faintness, and dyspnea. She was somewhat pale, with apical rate 70 per minute, blood pressure 90/50 mmHg, and soft abdomen. Several days before she had suffered from severe cough.

She gave a history of spontaneous abortion five years earlier and no other illness or surgery.

Observation and treatment of myocardial infarction were initiated. Approximately one hour after hospital admission she went into what appeared to be hypovolemic shock. She then was seen by two consultants who agreed on the diagnosis of internal bleeding, one mentioning rupture of splenic aneurysm. Fetal heart sounds were no longer audible at this time.

Her vital signs improved with intravenous fluids and blood replacement. She then was taken to the operating room. During exploration under general anesthesia, the abdominal cavity was found filled with blood and the spleen ruptured in the center of its convex surface. Since her condition was still critical and the fetal heart sounds already absent, it was felt that control of the bleeding was of prime necessity. After clamping of the splenic vessels, a lifeless-near-term baby was delivered by classical cesarean section. Resuscitation of the baby was unsuccessful. After splenectomy and completion of the section with further blood replacement, she recuperated uneventfully.

Now, seven years later, she is in good health and has two healthy children, one three years and the other three months old, both delivered by cesarean section.

Examination of the spleen showed an intraparenchymal area of bleeding beneath the site where the capsule had ruptured. Dr Winston Cozine, our pathologist, commented: "If the rupture of the spleen is related to underlying pathology, particularly a vascular anomaly, then the evidence has been destroyed."

Discussion

There is no clear answer as to the cause of rupture of the spleen during pregnancy. Moore and Lewis[1] found trauma, although often exceedingly slight, in about one-third of 44 patients, antecedent disease of the spleen (most commonly malaria) in about 15 percent, associated toxemia in approximately 10 percent; in the remaining 40 percent no other cause than pregnancy was apparent.

Shepard[2] suspected the increase in blood volume during pregnancy. It is interesting that aneurysm of the splenic artery, although a seemingly distinct entity, occurs five times more often in women than in men.[1] In the discussion of spontaneous rupture of the spleen without consideration of pregnancy, Dameshek and Ellis[3] rank malaria first and mononucleosis second as underlying causes.

What are the thoughts about the pathogenesis of spontaneous rupture? Bankole and Kent[4] believe the reports frequently indicate that the initial hemorrhage occurred a few days before the catastrophic rupture. The mechanism appears similar to two-stage traumatic rupture: subcapsular bleeding temporarily is contained by capsular tamponade but with increasing pressure leading to rupture of the capsule and frank bleeding into the vast space of the abdominal cavity. Perhaps the explanation of Mazel[5] would apply: "In traumatic rupture, the rupture is the cause of the hemorrhage . . . in spontaneous rupture, the hemorrhage is the cause of the rupture." Moore and Lewis[1] remind us that vascular ruptures of liver, adrenal glands, and other organs frequently have been described in toxemia. Sparkman[6] found ruptures of aneurysms and apparent normal uterine, ovarian, retroperitoneal, mesenteric vessels as well during normal pregnancy.

Byford[7] assumes that indirect trauma such as vomiting, retching, straining or coughing be responsible for the first stage of limited subcapsular bleeding with or without localized splenic disease. The latter is histopathologically destroyed by the distortion of massive bleeding following rupture of the capsule similar to the thought of our pathologist in the foregoing case report.

Comment

Whatever the cause, it was found that rupture of the spleen occurs more often during the last trimester of pregnancy, sometimes even during labor or in the immediate postpartum period.[1] Shepard[2] offered one most valuable practical bit of advice, consistent with the purpose of this report, to think of rupture of the spleen whenever a woman in late pregnancy goes into vascular shock without evidence of external bleeding.

However, at the time of shock the baby already may be lost and the mother may be in great danger. Therefore, when abdominal or left-sided chest pain with increasing abdominal tenderness and muscle guarding occur, one should be alerted. Immediate paracentesis may help an earlier diagnosis.

Summary

Spontaneous rupture of the spleen during pregnancy is rare but rapidly jeopardizes the lives of

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Adrenal imaging with radioiodocholesterol

Review of the University of Wisconsin Hospital experience

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CHOLESTEROL IS THE principal precursor for the various adrenal steroid hormones. Counsell *et al*[1] capitalized on this knowledge by synthesizing radioiodinated cholesterol, and in 1971 Beierwaltes *et al*[2,3] introduced imaging of adrenal glands employing ^{131}I-19-iodocholesterol.

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Adrenal scanning has become a reliable diagnostic aid in the evaluation of adrenal disease and a number of studies has appeared in the literature[4,5] describing a variety of pathologic adrenal states.

Adrenal imaging is noninvasive, can be performed as an outpatient and is relatively inexpensive when compared to alternative diagnostic procedures. The estimated radiation dose is acceptable,[6] and there have been no reported serious side-effects or reactions from the procedure.

We have been performing adrenal scans in our laboratory for three years and have found the procedure valuable in obtaining anatomical and functional information that has aided both endocrinologists and surgeons in patient management.

We report here our experience with adrenal imaging in 20 patients.

Material and method

Radioactive iodocholesterol was purchased from the University of Michigan Nuclear Pharmacy. Patients were started on Lugol's solution, 5 drops twice a day 24 hr prior to intravenous injection of the radiopharmaceutical to block thyroidal uptake of ^{131}I and continued for 10 days. Most patients were studied with 2 mCi of ^{131}I-19-iodocholesterol. More recently, patients have been studied with 1 mCi of ^{131}I-6-β-iodocholesterol.[7] Images were obtained with a gamma camera three and seven days post injection using a medium energy parallel hole collimator. The delay in imaging affords a higher target to background ratio.

Patients suspected of having adrenal dysfunction by abnormal laboratory results and clinical findings were referred to the Nuclear Medicine Laboratory for study. Informed consent was obtained from all patients prior to the study.

Results

Table 1 lists the patients studied, their scan findings, and final diagnosis. Twelve of the 20 patients studied were suspected of having Cushing's disease. Prominent bilateral adrenal visualization consistent with excess pituitary ACTH production was found in 8 patients.

SPLENIC RUPTURE . . .

baby and mother. Survey of the literature and discussion of possible causes and pathogenesis offer no clue for a high risk identification. Awareness of its possible occurrence more than anything else will allow for an early diagnosis.

In the one case reported here, the diagnosis of internal bleeding was made at the first signs of hypovolemic shock. One consultant considered the possibility of rupture of a splenic aneurysm. The patient responded promptly to intravenous volume and blood replacement and tolerated splenectomy and cesarean section well. However, the baby was lost. Severe coughing, with its stress on highly vulnerable blood sinus and vessels due to increased blood volume during pregnancy, was considered as the cause.

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Figure 1a is a representative normal adrenal scan seven days post injection. Figure 1b shows bilateral adrenal hyperplasia secondary to excess pituitary ACTH production three days post injection.

Four hypertensive patients, suspected of having aldosteronoma, were studied. One aldosteronoma was identified and confirmed at surgery, as shown in Figure 1c. This patient (number 15 in Table 1) was placed on dexamethasone suppression 0.5 mg four times a day starting two days before injection of the radioiodocholesterol. The scan shows a large area of markedly increased concentration in the left adrenal (arrow) on day 5 while the right adrenal is poorly visualized due to the dexamethasone suppression. Radioactivity outside the adrenal areas is in liver and bowel.

In two patients the diagnosis of adrenal carcinoma was suggested by the scan findings and confirmed at surgery. Figure 1d is the scan of case number 13 showing no visualization of adrenal tissue seven days after radioiodocholesterol.

An unusual case (number 19 in Table 1) of bilateral adrenal corti-

Table 1

Case	*Age*	*Sex*	*Indication for scan*	*Results*	*Correlative findings*
1	19	F	Secondary amenorrhea, elevated plasma testosterone	Normal	Left adrenal venography negative
2	64	M	HBP, low plasma renin	Bilateral suppression with dexamethasone	Nondiagnostic venography, increased aldosterone (plasma)
3	63	F	HBP	Normal	Final Dx=peripheral vascular disease
4	26	F	? Cushing's disease	Bilateral hyperplasia	Workup revealed pituitary excess of ACTH
5	38	F	? Cushing's disease	Early and prominent bilateral visualization	Surgery revealed bilateral hyperplasia
6	51	F	? Cushing's disease	Early and prominent bilateral visualization	Surgery revealed bilateral hyperplasia
7	31	F	? Cushing's disease	Early and prominent bilateral visualization	Surgery revealed pituitary adenoma
8	51	F	? Cushing's disease	Symmetric visualization at 7 days	Final Dx = consistent with excess pituitary ACTH
9	45	F	HBP, low plasma renin	No visualization with dexamethasone suppression	Final Dx = idiopathic edema, ? essential HBP
10	24	F	Hirsutism	Normal	Increased plasma testosterone from ovarian origin
11	52	M	Metastatic anaplastic Ca in lung, ? primary	Normal	Primary undetermined
12	70	M	? Cushing's disease	Left adrenal enlarged, right adrenal not visualized	Surgery revealed an adenoma of left adrenal; autopsy revealed a small adenoma of right adrenal*
13	36	F	? Cushing's disease	Nonvisualization (patient studied twice)	Surgery revealed carcinoma of left adrenal
14	28	F	? Cushing's disease	Early and prominent bilateral visualization	Surgery revealed bilateral hyperplasia
15	25	F	HBP, elevated plasma aldosterone (? aldosteronoma)	Increased activity left adrenal, right poorly visualized	Surgery revealed an aldosteronoma, left adrenal
16	56	M	? Cushing's disease, with mass superior pole right kidney	Nonvisualization	Surgery revealed carcinoma right adrenal
17	36	F	? Cushing's disease	Early visualization	Suppressed by low-dose dexamethasone. Dx = exogenous obesity
18	38	F	Virilization	Bilateral visualization on low dose	Followup revealed no abnormality
19	21	F	? Cushing's disease	Early and prominent bilateral visualization	Pituitary adenoma removed at surgery
20	59	M	? Cushing's disease	Early and prominent bilateral visualization	Surgery revealed bilateral hyperplasia

*No histochemical studies performed but presumed nonfunctional adenoma.

cal adenomas, in which one neoplasm was functional while the other nonfunctional, was studied. Other disease states studied included hirsutism, virilization, and metastatic carcinoma. One patient proved to have exogenous obesity.

Discussion

Normal adrenal glands are well visualized seven days post injection of the radiopharmaceutical. Indications for adrenal scanning are principally limited to three main categories: Cushing's disease, virilizing syndromes, and aldosteronism. The value of the procedure in patients with Cushing's disease is to identify the origin of the excess cortisol production. In Cushing's disease caused by bilateral hyperplasia, the adrenals will visualize early, usually by three days, and demonstrate an increased percent uptake of radioactivity as compared to normal glands, while Cushing's syndrome caused by a unilateral cortical adenoma, will demonstrate hyperfunction of the affected gland with ACTH suppression and nonvisualization of the contralateral gland.

Cushingoid patients who demonstrate no visualization of the adrenals are strongly suspect of having adrenal adenocarcinoma. In a series reported by Anderson and Beierwaltes[8] 2 of 7 patients demonstrating bilateral nonvisualization of the adrenals were proved to have adrenal carcinoma. Although the neoplasm is usually restricted to one side, increased amounts of steroid production suppress ACTH turning off the stimulus for normal steroid production in the contralateral gland.

Aldosteronoma is manifest on scan by unilateral prominence. Since asymmetry can be normal, the patient is suppressed with dexamethasone and the scan repeated. In normal patients both glands suppress and fail to visualize while in patients with an aldosteronoma the adenoma is unaffected while the contralateral (normal) gland is suppressed. The aldosteronoma within the gland is not suppressed because aldosterone production is not under the influence of ACTH.

Adrenal scanning may be of value in virilized patients since it may aid in identifying those in whom adrenal carcinoma is the cause. Testosterone producing carcinoma of the adrenal will not cause suppression of the contralateral adrenal gland but will result in anatomic distortion or lack of visualization of the affected gland.[8]

Conclusion

We have found that radiocholesterol adrenal imaging is a simple, accurate, and noninvasive procedure which correlates well with venography.[9] The test is a valuable diagnostic procedure which can be performed with currently available nuclear medicine equipment on an inpatient or outpatient basis.

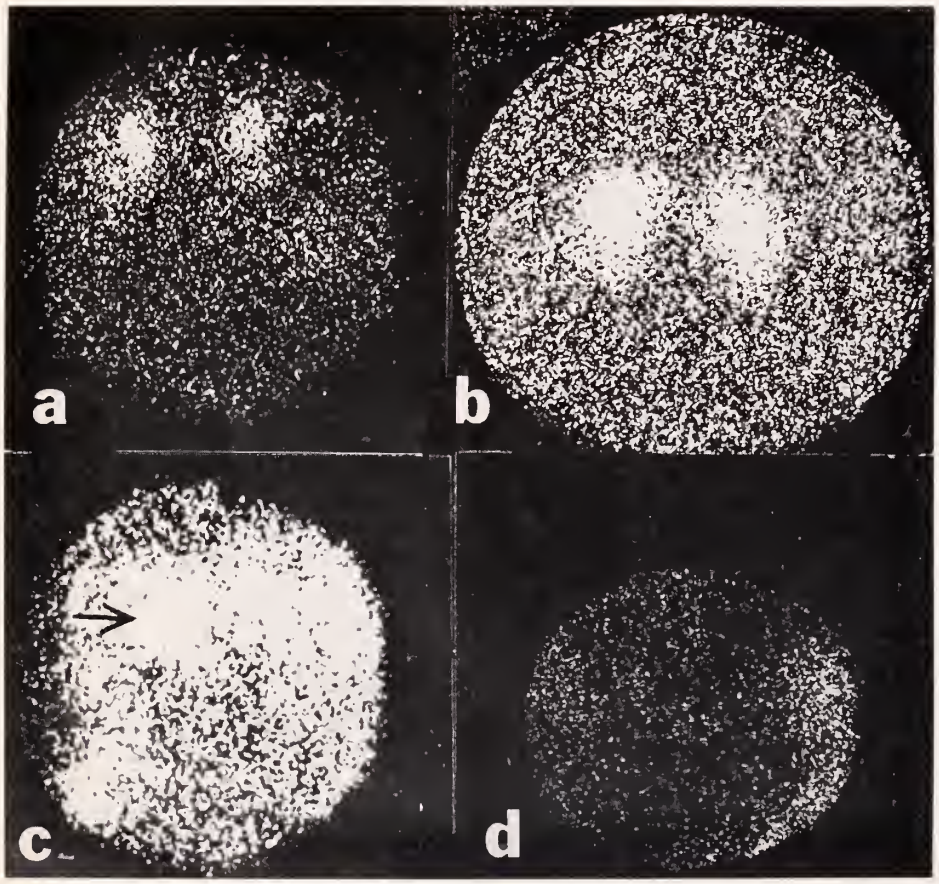

Figure 1—(a) Normal adrenal glands seven days after injection. (b) Bilateral hyperplasia three days post injection. (c) Left adrenal aldosteronoma. (d) Nonvisualization of adrenals in patient with adrenal cortical carcinoma.

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High output renal failure complicating surgery on the distal aorta

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MORBIDITY AND mortality resulting from renal failure after an operation on the distal aorta remain formidably high. This is particularly true for ruptured abdominal aortic aneurysms. A form of postoperative renal failure, termed high output failure, is being recognized with increasing frequency due to improved methods of diagnosis. Results of treatment of acute renal failure are improved if oliguric failure, dialysis and its complications can be avoided. Therefore, an effort to recognize renal failure as early as possible and an attempt to convert impending oliguric failure to high output renal failure improves results in our experience and is particularly applicable in community hospitals where dialysis is not readily available.

Patients and results

The records of 241 patients undergoing distal abdominal aortic surgery in the six-year period ending December 31, 1975, were reviewed. In 36 patients renal failure complicated the postoperative course. Renal failure was oliguric in 28 despite all measures to be described (Table 1), and seven met the criteria of high output failure, defined as progressive azotemia associated with a urine output greater than 30 ml per hour. These seven patients form the basis of this report. The age range was 60 to 68 years and averaged 63. Four patients had ruptured abdominal aortic aneurysms, one a rapidly expanding abdominal aortic aneurysm, and two had elective aneurysmectomies.

The pre- and postoperative values of the serum blood urea nitrogen and creatinine are given in Table 2.

Twenty-four hour urine volumes in all patients remained above 30 ml per hour. The highest 24-hour totals for urine volume in the postoperative days prior to reaching peak creatinine levels ranged from 950 ml to 4815 ml. Two of the seven patients were oliguric at some time in the postoperative course. Both had 24-hour urine volumes of 290 ml and 435 ml on the days the diagnosis of acute renal failure was

Table 1

		Survived	Died
Patients undergoing surgery			
Abdominal aortic aneurysms	159		
Bypass grafts	82		
Renal Failure			
Abdominal aortic aneurysms	(28 patients)		
High output failure		5	0
Oliguric failure		3	19
Bypass grafts (8 patients)			
High output failure		2	0
Oliguric failure		5	1

Table 2

	Range	Mean
Preop BUN	20-30 mg/100 ml	26 mg/100 ml
Preop creatinine	1.3-2.0 mg/100 ml	1.4 mg/100 ml
Postop peak BUN	94-174 mg/100 ml	143 mg/100 ml
Postop peak creatinine	4.2-12 mg/100 ml	9.2 mg/100 ml
Peak creatinine postop	4-15 days	8 days
BUN and creatinine return to normal postop	16-55 days	33 days

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EDITOR'S NOTE: Doctor Liebl is from Luxemburg, Wisconsin, and plans to return there to practice upon completion of his residency. Doctor RJ Gardner formerly practiced in Menomonie, Wisconsin, and is licensed in this state.

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Table 3—Typical postoperative course for the first ten days after operation on a patient in high output renal failure.

Day	*Operation*	*#1*	*#2*	*#3*	*#4*	*#5*	*#6*	*#7*	*#8*	*#9*	*#10*
Urine Volume....	2220	3925	4815	3645	4445	3420	2675	3155	3315	3635	1360
Urine sp gr.....	1.018	1.010	1.010	1.009	1.010	1.010	1.012		1.010	1.010	1.010
Urine osmolarity..		324	310					391			429
Urine Na+.....				104	110	87	92	62			
Urine K+				35	23	26	5	35			
BUN.....	22	31	47	63	94	95	92	90	93	85	79
Creatinine..	2.0	2.5	3.5	3.7	4.2	4.1	3.9	3.9	3.8	3.7	3.5
Creatinine clearance ..	66					24					
Weight	73.6	75.9	76.8	72.9	71.2	69.7	68.6	68		68.2	68.3

made, and were converted to a high output state by use of furosemide and appropriate volume and electrolyte replacement. Overhydration may precipitate congestive heart failure. An inadequate intravascular volume and furosemide administration will result in oliguric failure. Both states are lethal. On the days that the highest creatinine value was obtained, 24-hour urine volumes ranged from 920 to 4455 ml, with a mean of 2157 ml. No diuretic other than furosemide was employed.

The urine/plasma osmolarity ratio was less than 1.1 in all the patients both at the time of diagnosis and the postoperative day on which the highest creatinine was obtained, whereas, as previously mentioned, only two patients were oliguric at the time of diagnosis. Urine sodium on random sample was not as predictable as urine osmolarity, but was greater than 70 mEq/liter in most samples tested until after the serum creatinine began to decline. Urine potassium during this same interval only rarely exceeded 30 mEq/liter. No patient was ever hyperkalemic; the highest serum potassium level in any patient was 4.9. All patients were on potassium restriction, but avoidance of hyperkalemia was mainly achieved by maintaining a high urine output. Also, none of the patients had a clinically significant metabolic acidosis. The lowest carbon dioxide reading in any patient was 18 mEq/liter, and this only on one occasion. Most of the time the patients were in mild hypochloremic alkalosis secondary to the use of furosemide.

All patients survived; there was one late death from an acute myocardial infarction 14 months after operation. The typical postoperative course for the first 10 days after operation of one of the cases is summarized in Table 3. The patient was a 68-year-old male with longstanding hypertension who presented with an abdominal aortic aneurysm. An aortogram revealed the aneurysm extended up to the left renal artery, which was 95% stenotic. Left renal vein renin was 16.3 mg per ml per hour, while right renal vein renin was 6.2 mg per ml per hour. The patient underwent insertion of a bifurcation graft for correction of the aneurysm. The left kidney was then selectively perfused with a cold crystalloid-colloid solution for 30 minutes, and a side arm graft sutured to the left renal artery distal to the stenosis. In spite of this precaution, high output renal failure followed on the first postoperative day. The urine output was purposely maintained at a high level with furosemide, 40 mg intravenously every four hours and appropriate volume and electrolyte replacement. Recovery was uneventful.

Discussion

The important predisposing factors to acute renal failure in patients with obstructive or aneurysmal disease of the distal aorta are as follows: preexisting arteriolar nephrosclerosis, acute blood loss, cholesterol embolization, hemoglobinuria from multiple transfusion, myoglobinuria secondary to rhabdomyolysis in the lower extremities, acute pancreatitis, and jaundice. Each of these individually, or in combination, can cause renal failure. Preexisting renal disease was present in two patients in this series.

They had 24-hour creatinine clearances of 66 and 46 ml per minute respectively. Postoperatively when their serum creatinine was the highest, the creatinine clearance had declined to 24 and 19 ml per minute respectively. With resolution of the high output renal failure, renal function returns to normal, or to the preoperative level. In a group of nine patients reported by Shires[1] in high output renal failure, three patients died. From the autopsy findings he concluded that the distal

Table 4

	Urine volume	*Sp gr*	*Osmolarity*	*Urine Na+*	*K+*	*BUN*	C_{H_2O}	*Cosm*
Normal response to shock	Variable	Variable	Variable but usually >400	Variable		<20	May be poss C_{H_2O}	Average 200 ml/hr
Renal dysfunction (prerenal oliguria)	Oliguria	>1.018	>600 U/P ratio >1.3	<20	30-70	20-30	Neg C_{H_2O}	
High output failure	>30 ml/hr	1.003 to 1.010	300-350 U/P ratio <1.1	>70	<20-40	>30 ave. 80 peak	close to zero	
Oliguric renal failure	Oliguria	1.010 at dx.	300-350 U/P ratio <1.1	>70	<20-40	Usually >150 peak	close to zero	<40 ml/hr

nephron is the area of the kidney most sensitive to hypoxia, and that high output renal failure represents a less severe pathologic insult to the kidney than does oliguric renal failure, with a corresponding better prognosis. Our experience is much the same as is shown in Table 1.

Free water clearance is a convenient term referring to the water which is present in urine in excess of the volume of water needed to produce urine at the osmolarity of plasma. Osmolar clearance expresses the volume of plasma cleared of osmolar solute per minute. The formula for the two is:

$$\text{Cosm} = \frac{\text{Uosm} \times \text{U.V.}}{\text{Posm}} \text{ and } C_{H_2O} = \text{U.V.} - \text{Cosm}$$

Formula for osmolar clearance (Cosm) and free water clearance (C_{H_2O}), where Uosm = urine osmolarity, U.V. = urine volume, and Posm = plasma osmolarity.

If the urine is more concentrated than plasma, free water clearance will be negative. If the urine is more dilute than plasma, free water clearance will be positive. Under most circumstances, man excretes a concentrated urine thus, free water clearance is usually negative, and ranges from −25 to −100 ml per hour. It is now possible to predict impending renal failure days before the traditional indices, such as oliguria, azotemia, and an isosthenic specific gravity appear. Baek, et al[2] have shown that osmolar clearance gradually falls as patients begin developing renal failure, and three days prior to diagnosis by conventional means it already averages less than 40 ml per hour, in contrast to the usual value of more than 200 ml per hour. Of major significance is the early appearance of free water clearance approaching zero. Urine osmolarity then falls and approaches serum osmolarity, and becomes relatively fixed, even at varying states of hydration. In all of the patients in this series, the change in free water clearance occurred 72 hours before the diagnosis of acute renal failure was made using the classic indices of a rising blood urea nitrogen and creatinine and a low urine output with isosthenic specific gravity. Table 4 summarizes these concepts. Since the damage is primarily tubular, the urine produced in acute renal failure is essentially plasma filtered at the glomerular level.

Under normal circumstances, the renal cortex receives 75 to 80 percent of total renal blood flow, whereas the juxtamedullary cortex and outer medulla receive 15 to 20 percent.[3] After induction of acute renal failure in humans with nephrotoxins, there is not only a marked reduction in total renal blood flow but also a redistribution of blood flow within the kidney. The decrease in cortical blood flow is the primary contributor to the decrease in total renal blood flow.[4] The exact mechanism by which intrarenal blood flow is altered away from the cortex is still not known.

The renin-angiotensin system is also implicated in the pathogenesis of acute renal failure. This system may interact with vasopressin. Whereas physiologic doses of vasopressin inhibit renin release, angiotensin, even in very small doses, stimulates vasopressin release.[5] The rise in vasopressin is not dose-related to angiotensin, and the levels of vasopressin reached are in the range where it exerts a potent vasopressor effect.

We wish to emphasize the fact that high output failure can progress to oliguric failure. Why furosemide appears to be a useful drug in preventing oliguric renal failure remains controversial. There is some experimental and clinical evidence that dopamine, in low doses, can prevent or reverse established acute renal failure.[6]

Summary

This report presents data to support the proposition that oliguric acute renal failure can at times be prevented by early diagnosis and treatment of impending renal failure. After surgery every attempt should be made to keep the patient in proper fluid balance. This effort is aided by the judicious use of daily weights, central venous pressure, and pulmonary wedge pressure. By obtaining frequent urine specimens for osmolarity, sodium, and potassium, one can quickly calculate free water clearance and osmolar clearance, and therefore, an early diagnosis of renal failure can be made while the patient still has an adequate output. If urinary output falls, or if urine osmolarity approaches serum osmolarity, one should utilize furosemide. It is our distinct impression, with the proper level of hydration, impending oliguric renal failure can at times be converted into a high output state. Furosemide is administered in progressive doses until a diuretic response is reached, and then dosage is adjusted and given at four-hour intervals up to a total dosage of 4 gm per day. Urine output should be replaced ml per ml with the appropriate electrolyte solutions, as determined by urinary electrolyte measurements. The most significant advantages in being able to produce a urine output in uremia are the avoidance of dialysis, fluid overload, hyperkalemia, and subsequent cardiorespiratory death, which in all published series, is the most common cause of death. By use of this regimen, dialysis can be avoided in community hospitals.

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ABSTRACTS/ WISCONSIN AUTHORS

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Francis M Forster, MD, Modison, WNS Secretory for Continuing Medical Educotion

Oculocranial somatic syndrome: report of two cases

Floyd V Burton, MD; Paul G Gottschalk, MD; and Phiroze L Hansotia, MD, Morshfield

Oculocranial somatic syndrome with ragged red fibers is an uncommon neuromuscular disorder. Two further cases were described.

The first patient was a 57-year-old white female with known sarcoidosis who developed the onset of progressive right ptosis at age 46 years followed within two years by external ophthalmoplegia. Examination confirmed these findings and also revealed weakness of the sternocleidomastoid muscles and flexors and extensors of the neck. A CPK was elevated at 223 IU. An EMG revealed brief small amplitude potentials in most muscles examined. Left gastrocnemius muscle biopsy showed infrequent ragged red fibers.

The second patient was a 42-year-old white female who noted the onset of progressive left ptosis at age 15 years followed by progressive right ptosis and weakness of the cervical muscles at age 31 years. On examination there was bilateral ptosis, greater on the left, complete bilateral external ophthalmoplegia and weakness and atrophy of the temporalis, masseter and sternocleidomastoid muscles and flexors and extensors of the neck. There was also bilateral facial weakness and slight nasal dysarthria. A CPK was normal. An EMG revealed brief small amplitude potentials with increased recruitment in some muscles. Left infraspinatus muscle biopsy revealed three to five percent ragged red fibers.

Ragged red fibers do not appear to determine the clinical presentation of oculocranial somatic syndrome. ■

Fibromuscular dysplasia of the intracranial posterior circulation: a discussion of three cases and treatment

Phillip M Green, MD and Marc Letellier, MD, Marshfield

Fibromuscular dysplasia is a non-atherosclerotic angiopathy of small-sized and medium-sized arteries. Involvement of the cervical vasculature is uncommon and it is rarely found in the intracranial distribution of the carotid or vertebral and basilar arteries. Three cases of fibromuscular dysplasia of the intracranial portion of the posterior circulation were presented. Each case had signs of vascular insufficiency.

One patient presented with headaches, dizziness, and left homonomous hemianopsia. Another patient had nonspecific dizziness with transient loss of vision in the left visual field. A third patient had dizziness, intermittent leg weakness, and a right inferior quadrantanopsia. Angiography in all three patients demonstrated changes consistent with the diagnosis of fibromuscular dysplasia.

Therapy for this condition in the past has involved anticoagulation, Polin (1956), progressive dilatation with the DeBakey catheter, Morris (1968), excision and reanastomoses, Ehrenfeld (1967), and most recently the microvascular Yasargil bypass on the carotid reported by Sundt (1976). The latter two patients had microvascular anastomoses of the occipital artery to a portion of the posterior inferior cerebellar artery for revascularization. Both patients have been stable for five months suggesting that the bypass procedure provides a treatment for the unfortunate patients with the involvement of fibromuscular dysplasia in the posterior circulation. ■

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KEY TO NUMBERING SYSTEM: When a double number such as 2-37 appears, the first number refers to the month of issue; the second number to the page. When a single number such as S/130 appears, the number refers to the scientific section which is numbered consecutively through the 12 issues of the volume. The following table indicates the page numbers of the scientific section of each month.

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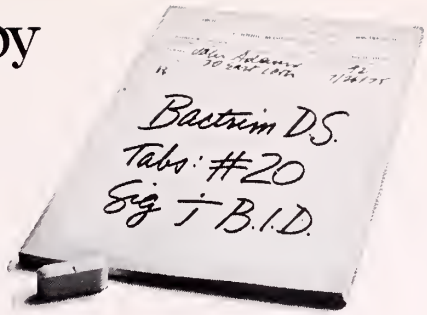
AMA GIVES FINANCIAL SUPPORT TO TV VIOLENCE PROJECTS

The American Medical Association will donate almost $150,000 to three projects studying television violence. *The Violence Index and Profile,* developed by George Gerber, PhD at the University of Pennsylvania will receive $107,000 in funds and services over three years from the AMA. Network television trends and possible impact of these trends are analyzed on a continuing basis by this study, which is based on a one-week sample of dramatic entertainment programming on the three major networks. The AMA will give $7,775 to the National Citizens Committee for Broadcasting to continue its monitoring of the amount of violence on prime time network programming during June. The committee studies the sources and supporters of television violence. The National Parent Teachers Association also will receive over $32,000 to help prepare and print a report of eight public hearings on television violence it sponsored. ■

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (*e.g.*, vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets Just 1 tablet B.I.D.

Bactrim™

(80 mg trimethoprim and 400 mg sulfamethoxazole)

2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

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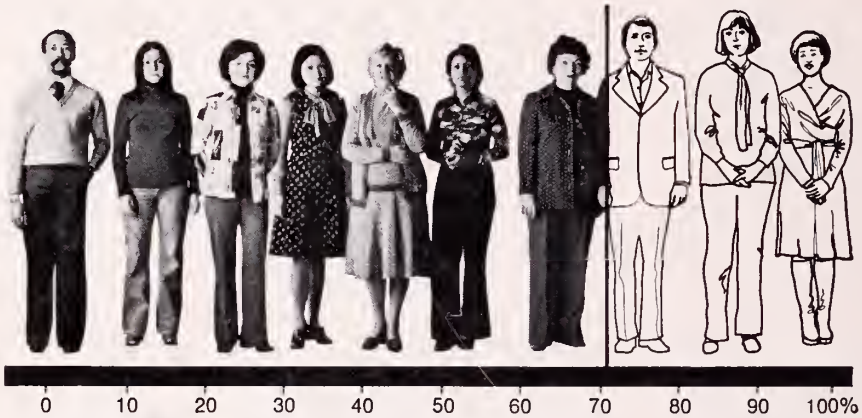
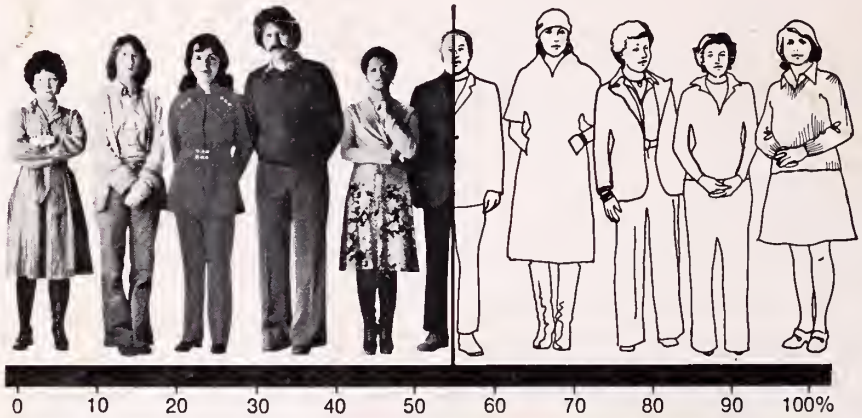
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets Just 1 tablet B.I.D.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Please see summary of product information on preceding page.

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wisconsin medical journal

DECEMBER 1977

INSIDE

Experience with laminar airflow in the management of major burns at the University of Wisconsin burn unit

Text of SMS comments opposing proposed national guidelines for health planning, involving HSAs

INDEX ISSUE: Volume 76, January 1977-December 1977

Now, two dosage forms

Nalfon®
fenoprofen calcium

300-mg.* Pulvules® and 600-mg.* Tablets

DISTA

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. and 691.8 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. and 600 mg. fenoprofen respectively.

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A character all its own.

Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® CIV

chlordiazepoxide HCl/Roche

5 mg, 10 mg, 25 mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE Roche Products Inc.
Manati, Puerto Rico

Please see following page.

THE ANXIETY-SPECIFIC.

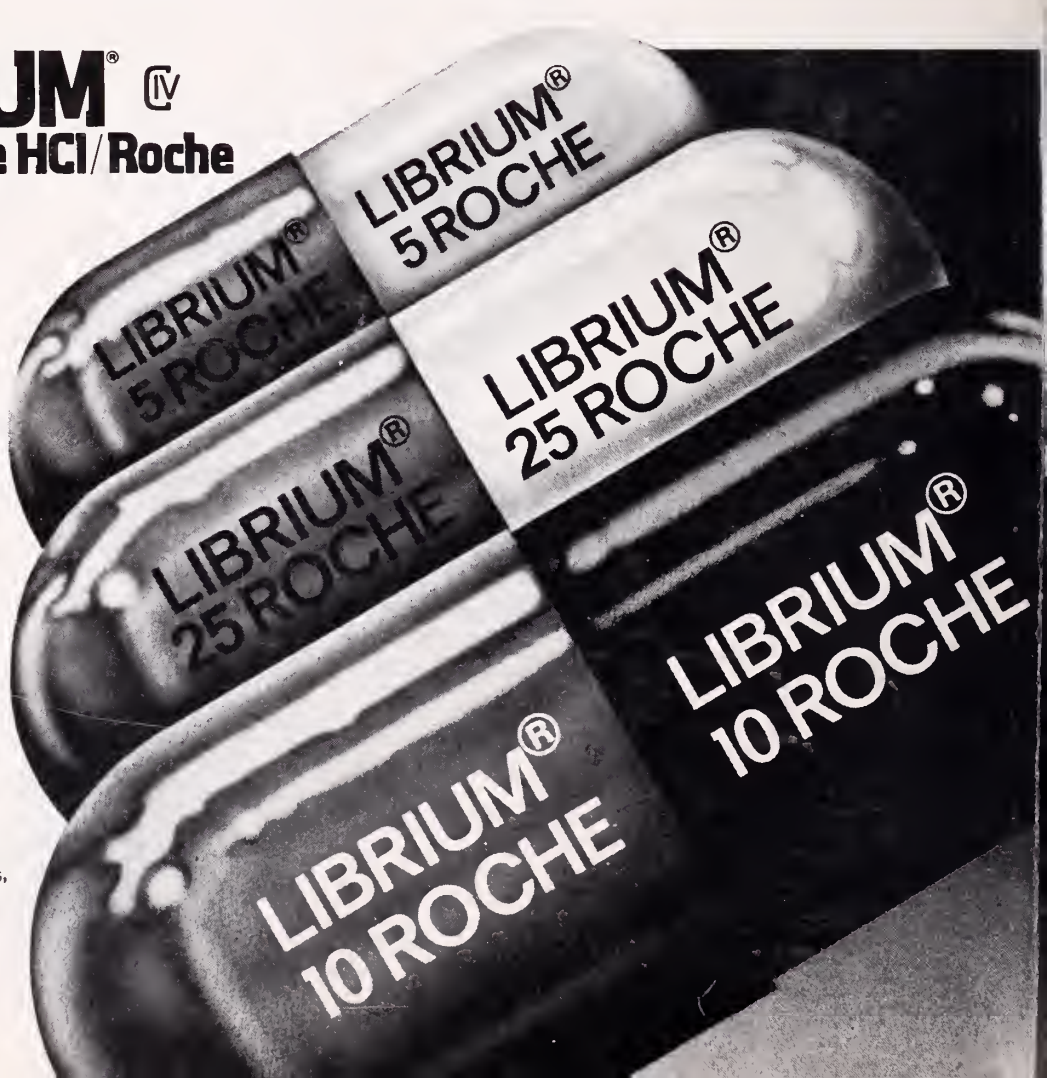
Since its discovery in the research laboratories at Roche, Librium has been the object of ongoing pharmacologic and clinical investigation.

The published record on Librium is enormous. So large, in fact, we put it into a computer literature retrieval system to make it more accessible in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® CV
chlordiazepoxide HCl/Roche



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*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

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